THE

LARYNGOSCOPE.

VOL. VIII. ST. LOUIS, MO., MARCH, 1900. No. 3.

ORIGINAL COMMUNICATIONS.

(Original communications are received with the understanding that they are contributed exclusively to THE LARYNGOSCOPE.)

A CASE OF FATAL SPHENOIDAL SUPPURATION.*

BY SAMUEL LODGE, JR., M.D.

Surgeon to the Eye, Ear, Throat and Nose Department of the Royal Halifax Infirmary.

W. S., thirty-one, pawnbroker, was admitted into the Royal Halifax Infirmary on May 15, 1899, complaining of constant pain in right ear and right side of face of six months' duration. For the last two months the right side of his face has been swollen and there has been a copious discharge of matter, often mixed with blood, from the right nostril.

Patient had always been a fairly healthy man. Clear history of syphilis about nine years previously. He had been married nine months. His wife had never been pregnant. Patient was unable to sleep well on account of the constant pain.

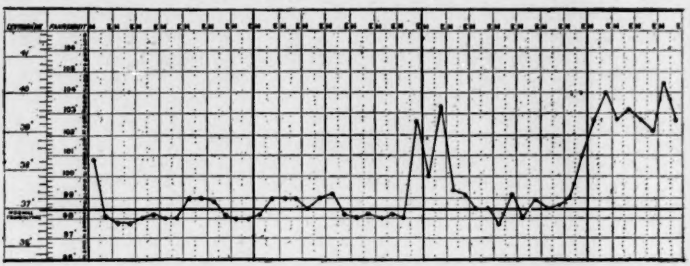
Prior to his admission he had been seen in consultation with Drs. Topham and Marshall who had for some weeks carried out vigorous antiseptic treatment.

On Admission.—Temperature, 100°. Skin over right superior maxilla red and edematous, teeth in fair condition. Discharge of thick pus from right nostril coming from region of superior meatus. Sequestrum in region of cribiform plate diagnosed. Nothing abnormal found in ears. Post rhinoscopy disclosed nothing abnormal. Chest and abdomen natural. Urine, sp. gr. 1014; no sugar; trace of albumen.

* Communication read before the Leeds and West Riding Medico-Chirurgical Society November, 1899.

Ophthalmoscopy.—Fundi normal.

May 16th. Antrum of Highmore explored with Lichtwitz's antral trocar. Boric acid solution used for flushing antrum returned free from pus. Patient expresses himself as feeling better to-day, temperature normal. Alkaline wash prescribed for nose. Patient had been taking 60 grains of iodide of potassium thrice daily before admission, as well as inunctions, so it was thought safe to-day to reduce dose to gr. 30 ter die.



Patient continued to feel much better, took interest in what was going on in the ward and was allowed to get up part of the day.

May 26th. K. I. increased again to 60 grains 3 die.

May 28th. Rigor in evening, temperature rose to 102.6°.

May 29th. Patient no better; M. T. 100°; E. T. 103.4°.

June 4th. Patient worse; E. T. 101°.

June 5th. Patient drowsy; M. T. 102.6°; E. T. 104°.

June 6th. M. T. 102.6°; E. T. 103.2°.

June 7th. Patient comatose. Tongue and lips covered with sordes, discharge from nostril more copious. Head slightly retracted, slight external strabismus. Constant twitching of left arm. Pulse 88, full and bounding.

Respiration 24, M. T. 102.6°; E. T. 102.2°.

June 8th. M. T. 104.4°; E. T. 102.6°.

Patient gradually sank.

Post-Mortem Examination.—Scar on penis from old sore.

Skull.—The base of brain was bathed in thick greenish pus, principally in neighborhood of pituitary body, the pus extended backwards over pons and medulla. No brain abscess. Ventricles contained more than normal amount of fluid.

Frontal sinuses normal.

Cribriform plate of ethmoid and ethmoidal cells normal.

To the right of the sella turcici there was some necrosis of walls of sphenoidal sinus. Probe readily passed from base of skull through sphenoidal sinus into nose. There was a large free opening from sinus into nose. The sinus was full of thick muco-pus. Cavernous sinus not thrombosed. Right antrum of Highmore opened contained about a drachm of thick glairy mucus.

Lungs.—Bases edematous, otherwise normal.

Remarks.—About eight years ago the patient had consulted me for severe secondary pharyngitis which speedily subsided under the usual treatment. I think that most rhinologists find that their severest cases of tertiary syphilis rarely terminate fatally if vigorously pushed medicinal treatment and the requisite surgical measures be adopted. The patient bore examination of his nose badly and the flow of pus from his right nostril was so profuse and persistent that its rapid reappearance after cleansing the nose made anything like a satisfactory examination next to impossible. The discharge coming away anteriorly and from a point above the middle turbinal led to the exclusion of maxillary, frontal, anterior ethmoidal, and sphenoidal empyemata. The edema of the right cheek suggested exploration of maxillary antrum. The results being negative, the edema was put down to some condition in the nose impeding the venous return. Necrosis of the roof of the nose was diagnosed, coupled possibly with posterior ethmoidal sinusitis. The copious flow of pus and the steady improvement of the patient for some days after his admission led one to assume that pus was not pent up, and that to explore more thoroughly the roof of the nose and posterior ethmoidal cells would be likely to break down the natural rampart of granulation tissue and thus expose the cranial cavity to pathogenic invasion.

The sudden onset of septic meningitis dissipated this feeling of security. The opportunity for successful surgical interference had been allowed to glide by. Nevertheless grave risks to live as well as to important structures (*e. g.*, contents of right orbit) would necessarily have been incurred by the complicated surgical technique required. But the labors of Macewen and others in the analogous conditions met with in destruction of the tegmen tympani, or other parts, in middle-ear disease, have demonstrated that even in this situation much, if not everything, might have been accomplished by a careful but bold surgeon operating on similar lines.

My thanks are due to our late senior house surgeon, Mr. W. A. Dickson, for much valuable help in the conduct of this case.

REPORT OF A CASE ILLUSTRATING THE IMPORTANCE AND POSSIBILITIES IN THE EARLY RECOGNITION AND TREATMENT OF MALIGNANT GROWTHS OF THE LARYNX.*

BY W. K. SIMPSON, M.D., NEW YORK.

Chief of Clinic and Instructor in Laryngology, College of Physicians and Surgeons, N. Y (Col. University); Fellow American Laryngological Association.

Pt.—J. R., male, forty-four, cook. Seen first by me on September 22, 1896, giving a history of progressive hoarseness for a period of two months, becoming markedly worse during the last two weeks. Otherwise the patient's history was negative. Examination of the larynx at this time revealed a moderate-sized papillomatous growth, slightly pedunculated, very white in color, springing from the free edge of the right vocal cord at about its center; the mucous membrane of the vocal cords and the remainder of the larynx were very red, indeed, making the contrast with the growth very marked. There was an entire absence of any induration or other conditions pointing to malignancy, the whole aspect of the growth giving the

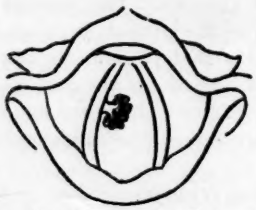


Fig. 1. Sept. 22, 1896. Before first removal.

appearance of being entirely benign in character. On October 4, 1896, I removed the growth with the tube forceps, using a two per cent solution of cocaine; an apparently clean removal was made at the first attempt; there was no bleeding, and a good return of voice. The pathologist reported that the growth was a simple papilloma. The patient progressed most favorably for about nine weeks, when the hoarseness returned, and an examination on December 13th, same

* Read before the Section of Laryngology, New York Academy of Medicine, January 24, 1900.

Fig. 2. Dec. 13, 1896. Nine weeks after first removal.

year, revealed a recurrence by the presence, at the original site, of two distinct growths. (Fig. No. 2.) During the interval between December 16, 1896, and January 24, 1897, the patient suffered from an attack of pneumonia. On January 24, 1897, I removed the two recurring growths, which had somewhat increased in size; the removal, by tube forceps, was made in two attempts, using a mixture for anesthesia of one per cent solution cocaine and two per cent eucaine; owing to an unsatisfactory anesthesia a two per cent solution of cocaine alone was substituted, which answered the purpose. A fairly large quantity was used, both by spray and application, but no systemic symptoms of cocaine followed.

Though the general appearance of the two recurring growths was benign in character, the space between them was a little thickened, which suggested that there might be a further extension of origin beneath the free edge of the vocal cord.

Fig. 3. Jan. 24, 1897. Immediate appearance after second r.moval.

The removal demonstrated this to be the case. It was owing to this suspicion that in the removal I included a considerable portion of the underlying tissue (Fig. No. 3), leaving two cleanly-cut crescentic spaces.

The microscopical report on these first recurring growths, by Dr. John S. Thacher, pathologist to the Presbyterian Hospital, was as follows: "Epithelial layer considerably thickened; in places there are islands of epithelial cells surrounded by connective tissue. There is quite a regular mixing of the epithelial and connective tissue structure. Many of the epithelial nuclei show mitotic figures; there are numerous leucocytes in the connective tissue and a few have made their way between the epithelial cells. The growth should probably be classed as an epithelioma."

January 27, 1897.—Three days after second removal the vocal cord, though clear, save a very minute pin-head remnant, had become somewhat red, with a loss of its normal sharp contour. The left (other) false cord had become somewhat thickened and overlapped the true cord in phonation, and there seemed to be a slight tearing on its surface. This I attributed to a possible traumatism during removal.

January 31, 1897.—One week following removal there was about the same general appearance as on the 27th, though the voice was somewhat better and a slight tendency to clearing up of the left false cord.

February 7, 1897.—No thickening of the originally affected cord, though the pin-point remnant shows signs of being more defined; the left false cord is better in appearance.

February 14, 1897.—Voice becoming better; general appearance of larynx some better, excepting slight remnant of the wound of the left cord; the growth at original site increasing in size. In view of the microscopical report and the apparent confirmation of malignancy by the tendency to rapid recurrence and general aspect of the larynx, I sent the patient, on February 15th, to Dr. C. H. Knight in consultation, especially as to the nature of any subsequent operation. He concurred in the opinion that there was a strong suspicion of malignancy, and in the event of no change for the better, suggested laryngeal fissure as a suitable operation in so early a case.

February 22, 1897.—The voice has been about normal for two days. The right vocal cord still a little red, in streaks; no thickening or induration; a small but increasing papillomatous growth marks the site of the original tumor. It is whitish in color and every appearance of being benign. The left side of the larynx is assuming a natural condition. The whole larynx is taking on condition as when first seen, only the recurring growth is smaller than the original.

Fig. 4. Feb. 23, 1897. At time of third operation.

February 23, 1897.—About fourteen weeks after the first operation I removed, for the third time, with tube forceps, the recurring growth, making at one attempt a clean and deep removal. I followed the removal with a deep galvano-cauterization, using a flat-guarded electrode. (Fig. 5.)

Fig. 5. Appearance after third operation.

February 28, 1897.—Larynx is remarkably clean, with no remains of cauterization or growth; redness of the right vocal cord entirely disappeared; voice good; there has been a slight soreness from the cauterization; motion of larynx is good.

March 7, 1897.—There is still no trace of growth, its site being occupied by a slight concavity due to the combined removal and cauterization. From that date to this, January 20, 1900, a period of three years and three months from the date of first operation, there has been no further recurrence, either of hoarseness or of the growth, and the patient has expressed himself as having been in extremely good health. A microscopical report of the small last growth removed, made by our colleague, Dr. Jonathan Wright, classes it as a papilloma.

It might be stated that the specimen sent Dr. Wright was a very small one and from the superficial portion of the growth.

Though from the history and final result of the above case it might appear from a clinical standpoint as if we had to contend with a recurring papilloma, still I think it will serve to emphasize some important and positive points in the consideration of laryngeal growths in the adult. Among them may be mentioned the important fact that all new laryngeal growths in the adult, especially of a recurring nature, however simple in appearance, should always be regarded with suspicion, and our prognosis governed accordingly, realizing that the relation between benignity and malignancy is often so close that the line of demarkation is indeed difficult to define.

Secondly, The difficulty and anxiety attending a positive diagnosis in *very early cases*, where a period of transition is apparently present, and where the microscopical examination admits of some doubt.

Thirdly, The satisfactory results which may sometimes attend our efforts at treatment, by a thorough removal of the growth and destruction of the underlying tissues, remembering that even in some cases of early recognition and removal, where an absolutely positive diagnosis of malignancy has been substantiated, a cure may be effected without resorting to the major operation of laryngectomy.

ITCHING OF THE AUDITORY MEATUS.

BY ALEX. W. STIRLING, M.D., C.M. (EDINB.), D.P.H. (LOND.) ATLANTA.

I have been led to think by one or two cases which I have recently had under my care that a cause of irritation and even furuncle of the external ear may perhaps not infrequently be overlooked. I refer to an irritation arising in reality near the pharyngeal mouth of the Eustachian tube, and transferred to the ear. I have observed that the inflamed appearance of the meatus may be caused to entirely disappear by medication and strict orders that the ear is not to be scratched while the itching may continue. Also, that itching of the meatus may be caused by applications near the Eustachian orifice, and may be relieved by sedatives to the same region. I have a strong suspicion that the order of events may not infrequently be: first, an inflammatory condition of the pharynx giving rise to intense itching of the ear; second, scratching of the ear with removal of the protecting epithelium; and third, inflammation of the skin with local pain or itching.

It follows that treatment, to have a permanently good effect, must attack the pharynx as well as the ear.

THE SILVER SALTS IN THE TREATMENT OF CHRONIC SUPPURATION OF THE MIDDLE EAR.*

BY E. B. GLEASON, M.D.

Clinic Professor of Otology, Medico-Chirurgical College, Philadelphia.

Argentic nitrate has been used from time immemorial in the treatment of aural diseases. The application of silver nitrate to the drumhead in chronic catarrh of the middle ear was a favorite method of treatment with Sir William Wilde, who stated that it relieved tinnitus and improved the hearing. His explanation was that it causes exfoliation of the epidermal layer and thus diminishes the thickness of the drumhead. Wilde attached undue importance to the part played by the drumhead in the function of hearing, and the beneficial results recorded were probably not the effect of exfoliation of the epidermic layer, but were due to the sedative effects of the silver deposited in the tissues.

Solid silver nitrate when applied to moist tissue is a feeble cauterant, producing a superficial slough. Solutions of silver nitrate produce such very superficial sloughs that they may be classed as irritants; or, when very diluted, as stimulating astringents and antiseptics. The antiseptic properties of the silver compounds should not be lost sight of. If a silver wire be allowed to remain in a culture medium, many of the more common bacteria cease to grow in the immediate vicinity of the silver.

When a solution of silver nitrate is painted upon a mucous surface it is decomposed and organic silver compounds are formed. These are further decomposed, with the final result of the formation of argentic oxide; which, if in sufficient quantity, stains the tissues a characteristic bluish-black color. Nitrate of silver is an irritant; the organic compounds resulting from its application to mucous surfaces are, however, sedative.

Whether the irritant or sedative effects of silver nitrate predominate, depends largely upon the character of the epithelial layer of the mucous membrane to which it is applied. If a sixty-grain solution be painted upon the posterior wall of the pharynx the irritating quality is manifested and produces discomfort, persisting for some time. If, however, this solution be painted upon inflamed tonsils and the inflamed lateral wall of the pharynx, the primary irritant

*Read before the Section of Otology and Laryngology of the Philadelphia College of Physicians, January 17, 1900.

qualities of the nitrates are scarcely perceptible and the procedure is followed by a sense of great relief and comfort. Painting with a sixty-grain solution the lateral walls of the pharynx once in twelve or twenty-four hours indeed is one of the best methods of aborting acute pharyngitis and tonsillitis.

Application of solid nitrate of silver to the stump of a polypus, or to granulation tissue, was a favorite method of treatment with the otologists of a generation ago. It produces a smaller slough than chromic acid, and is more irritant than trichlor-acetic acid. Its application is followed by increased discharge during the period that the slough is separating. In chronic otorrhea, solutions as weak as ten grains to the ounce, when applied to the mucous membrane of the atrium or injected into the attic, produce increased discharge for a varying period, after which the discharge is sometimes diminished.

The use of solution of nitrate of silver in the treatment of chronic otorrhea has not been markedly successful, for in the majority of instances the irritating effects of the solution have overshadowed the antiseptic and astringent properties of the silver and rendered progress slow. In cases requiring an astringent, alcohol diluted to a greater or less extent renders better service; and in cases where granulations were neither large or numerous, better results are obtainable by the so-called dry treatment with powdered boric acid.

Manifestly with alcohol and even with boric acid, in the majority of cases it was evident that I was employing an irritant; and many of my cases, with large perforations, did better by simple cleansing of the exposed intra-tympanic membrane with absorbent cotton which has been sterilized by scorching over the flame of a lamp after being wrapped about the end of a probe. It is, of course, nearly impossible to apply powdered boric acid to the attic, and in attic cases, syringing with an antiseptic solution and carefully drying the parts is all that is available in the way of treatment without resorting to surgical intervention.

When the statement was made that certain organic silver salts were astringent to mucous membranes, without being in the least irritating, my expectation was that they would prove most valuable in the treatment of prolonged otorrheas in which the attic and probably the mastoid antrum were involved in a suppurative process.

The most popular of these organic silver salts are Argonin and Protargol. As in solution the former is somewhat unstable and when partially decomposed is said to be irritating, my experience has been confined to the latter. As an injection in gonorrhea it has been most successfully used in one-half to two per cent solutions.

In various forms of conjunctivitis with but few exceptions it yields excellent results when applied to the palpebral conjunctive in a five per cent solution; ten per cent and even twenty per cent solutions may be used in the eye without producing more than transient irritation.

In the following cases of prolonged otorrhea a hypodermic syringe full of a five per cent solution, by means of a Blake's cannula, was injected as high up into the attic as possible. The parts then were massaged with Siegle's pneumatic speculum, in order, if possible, to force a portion of the solution into more distant parts than could be reached with the syringe. The ear finally was carefully dried by means of absorbent cotton. Before using the protargol the middle ear had been cleansed with the aid of Blake's cannula and dried in the usual manner.

Case I.—Robust man of about fifty. Remains of the drumhead, malleus and part of the scute had been removed about two years before. In spite of repeated curettment of the accessible portions of attic and the use of chromic acid fused on a probe, and instillations of alcohol, the ear continued to secrete a scanty, fetid discharge. After one injection of protargol the ear became absolutely dry and the visible parts cicatrized.

Case II.—Young man of about twenty-one, a seminarian. Had been under the care of a competent aurist without benefit for the period of two years, one year before I saw him. Had since contented himself with syringing the ear with boric acid water and drying the parts. Discharge somewhat abundant and slightly fetid. Lower segment of drumhead lacking. Posterior to malleus, from a sinus, a small polypus was removed with Allport's forceps and protargol injected. One week afterward, there was a scanty, odorless discharge, some of which had dried in upper part of the canal. Protargol injected the second time the patient went home for the holidays, and on his return, three weeks afterwards, the parts were found absolutely dry and the visible portions of the middle ear cicatrized.

Case III.—A girl fifteen years of age. Remains of drumhead, malleus and scute had been removed about a year and a half before; incus not found. Ear had continued to discharge since the operation through a sinus at the upper portion of a cicatricial drumhead. After the first injection of protargol the discharge becomes scanty and odorless. A second injection was given at the end of a week. The patient failed to visit the office for nearly three weeks, but stated that it had been unnecessary to cleanse the ear since her last visit. A considerable quantity of inspissated secretion was seen in the lower portion of the canal. Two injections of protargol were then made at intervals of three days, but without bringing about an entire secession of the discharge.

Case IV.—Man of about thirty-five. Otorrhea for twenty years. Polypi have been removed from time to time from the attic during last year or more. Ear continued to discharge varying quantities of pus. Patient somewhat irregular in attendance. Refused operative procedures except removal of polypi. Ear became dry and cicatrized after two injections of protargol.

I have used protargol in only these four attic cases, as cases of this kind are somewhat rare and I could not quickly collect together a large number. I am aware that "one swallow does not make a summer," but I have submitted this preliminary note because the cures having been so speedy in three of the cases would indicate that we have in protargol an antiseptic and astringent superior to any now used in the treatment of chronic middle-ear suppuration, and much more easy of application than any of the powders. Protargol, of course, will not remove the ossicles in cases where their presence interferes with proper drainage. It will not remove accumulations of cholesteatomatous material from the attic and antrum in cases requiring a radical mastoid operation. It will not remove polypi. It is, however, in a five per cent solution, an astringent and antiseptic quite unirritating to the middle-ear mucous membrane.

I have used the five per cent solution in the auditory canal, the atrium, and also in the pharynx, with success in decreasing inflammation and modifying secretion. Unlike nitrate of silver solutions, it is unirritating to the posterior pharyngeal wall. It does not sear the tissues, and hence penetrates more deeply than nitrate of silver solutions, but produces no stain either upon the mucous membrane or the skin. For controlling hemorrhage, or searing the stump of an aural polypus, protargol is greatly inferior to nitrate of silver.

A reference to the literature of the subject would indicate that protargol previously has not been used in the treatment of aural diseases. Although Benario, in an article dealing with the antigonorrheal properties of the drug, states (*Deutsche Med. Wochenschrift*, No. 49, 1897): "I do not doubt that many indications for the use of protargol will arise in otological and rhinological practice, especially in bacterial affections, and that it will prove serviceable in the treatment of gastric ulcer."

REPORT OF A CASE OF PERSISTENTLY RECURRING EPISTAXIS.

BY C. C. STEPHENSON, LITTLE ROCK, ARK.

Though most cases of nose-bleed terminate favorably, the following would seem to merit a report, in view of its severity and persistent recurrence.

J. T. B., white, male, æt. twenty-eight, laborer, was referred to me October 20th, by his family physician. He gave the following history: Four years ago, while working with a threshing machine in Oklahoma, his nose began to bleed at about 10 o'clock in the morning without any provocative cause. Being in the best of health, and not subject to nose-bleed, not much attention was paid to the matter in the beginning, supposing that it would stop spontaneously. After using cold water it seemed to show indications of persistence by getting worse; the water was kept up for awhile, and finally he had to quit work. The bleeding becoming more violent he went to his home and assumed a recumbent posture, and used the various little domestic remedies, one after another, till finally in four or five hours the bleeding stopped. The next day he began work again, resulting in about the same experience as the day before, and for a week afterwards he had slight attacks at intervals during the day, and while asleep at night it would awaken him. Finally it stopped altogether and did not recur for a year, when, without any ascertainable cause, he had another attack, lasting about a week or ten days, bleeding at intervals as before. He had no more trouble until this year. August 20th last he was firing some charges of dynamite in blasting rock five or six miles from the city, when he began suffering from a violent headache, which produced another attack, due undoubtedly to a transient congestion, followed by the engorgement of the nasal vessels to such an extent that ruptures in both vessels and the mucous membrane probably resulted.

The bleeding was so profuse that he had to quit work at once and return to his home. He again used the ordinary little agencies of a domestic type to check the bleeding, but was unsuccessful, and becoming discouraged he sent for a physician—the first time one had been called. A prescription was given him that controlled the hemorrhage without trouble, but a recurrence took place that

night while the patient was asleep, and was accompanied by a headache. Again the prescription was used successfully.

The next day his nose began bleeding again, and again he sent for his physician. He was unable to get him, and the same prescription was used again, but without any perceptible benefit. Another physician was called, who prescribed and succeeded in stopping the bleeding, though not until after plugging the anterior nares. From this time on he had nasal hemorrhages daily, and then during the night it would waken him from sleep. When I first saw him anemia was present to an extreme degree, and he was so weak that the slightest exertion would prostrate him. He was as near bloodless as any one could be. In fact he presented a picture of profound prostration. His pulse was ninety and his temperature ninety-eight. Both anterior nares were plugged with some dirty cotton that had a small quantity of pulvis acacia dusted on. These plugs had been in situ for thirty-six hours and there was a continued oozing of the mixture, composed of serum, blood and nasal mucus, and on removal a large decomposed clot was detached and liberated through the mouth, emitting a very foul odor. The oozing continued about the same after the removal of the plugs and clot. I first sprayed his nose with a carbolized solution, using weak pressure of only eight pounds of compressed air in my reservoir lest I should rupture the membranes by the usual pressure of twenty pounds. I next proceeded to cocainize both nasal cavities with a ten per cent solution, which produced constriction of the blood vessels and check the oozing. The mucus seemed to discharge with renewed activity, and I soon discovered that I had a rhinorrhea complicating. I now sprayed with Seiler's solution, and the amount of mucus discharged appeared incredible. After clearing both fossæ, so that I could see clearly, I began searching for bleeding points, not expecting, however, to locate any, as I suspected that these hemorrhages had their origin in the adjacent sinuses, the persistent character of the case pointing to this. My supposition was that the various remedies that had been employed with the plugging of the nares failed to come into direct contact with the solution of continuity. However, branches of the spheno-palatine artery were easily discernible upon the septum and the least interference would cause bleeding. My first impulse was to cauterize with electricity. I reapplied a ten per cent of cocaine to the parts and proceeded to touch the ruptured points, using cherry-red heat. The results at first were magical. A two per cent solution of menthol in liquid alboline was

sprayed and both nares plugged with bichloride gauze, cut in strips an inch wide, and the patient was given strychnine, iron and ergot, and a plentiful diet of milk, eggs and beef. I saw him the next day and found him worse. My eschars, instead of acting as protectives, became detached on removal of the plugs, which were saturated with blood. Another large clot was dislodged, and the rhinorrheal discharge came pouring out as it did the day before. I sprayed again with Seiler's solution, and then cocainized the parts and reapplied the plugs. I had now come to regret the use of the electro-cautery, as I had a raw surface to deal with at every place touched with the electrode, yet it was used in the most delicate manner. The next day about the same condition was present, except the rhinorrheal discharge was less this time. I insufflated a powder composod of antipyrine and tannin, using a small bulb insufflator. Afterwards the plugs were reapplied, which I began to see were indispensable. This calls to mind Casselberry's case (De Schweinitz "Diseases of the Eye, Ear, Nose and Throat," page 904) in which he saved the life of one patient through required packing for a period of five weeks. My patient's condition remained about the same in spite of all the agents used, the only beneficial one of which was cocaine. I gave him a prescription for a ten per cent oily solution and directed him to spray every two hours. All other remedies, as packing, powders, cauteries and ointments were discontinued. He began to improve, and remained in my care four weeks, gaining twelve pounds. The fifth week he began work blasting rock, and continued all right after a week of such labor, with no recurrence of hemorrhage whatsoever. Since then, unfortunately, I have lost sight of him, and am unable to say if the cure is permanent. This man had persistent attacks of nose-bleed daily and nightly from one to several times during twenty-four hours, covering a period of three months, completely incapacitating him for work.

The ideas which I wish to emphasize in reporting this case are the value of the soothing agents applied with the less degree of force and the unsatisfactory results following the use of the electro-cautery and cauterizing with the solid stick of nitrate of silver and chromic acid in persistent epistaxis.

Masonic Temple.

SOCIETY PROCEEDINGS.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON LARYNGOLOGY AND RHINOLOGY.

Stated Meeting, January 24, 1900.

Wendell C. Phillips, M.D., Chairman.

An Improved Powder Blower.

Dr. J. F. McKernon exhibited a simple powder blower which could readily be kept clean. It had a screw cap which prevented the cork from being blown out of the bottle by the air pressure.

Capillary Adenoma of the Thyroid with Carcinomatous Degeneration Causing Laryngeal Symptoms.

Dr. M. D. Lederman reported the case of a man, forty-six years of age, a singer in the synagogue, who had been following this calling for many years. One day on reaching home a swelling was noticed on the left side of the neck. At that time Prof. Frankel, of Berlin, had examined the larynx with negative results. No operation had been attempted for fear of injuring the laryngeal nerve. Prof. Kirstein had then seen the case, and had made a diagnosis of cystic goitre. After removal of some of the fluid the man's voice had improved somewhat, but the fluid had quickly returned. When seen by Dr. Lederman two years ago there had been a local swelling of the thyroid gland. The man was quite hoarse and sought treatment on this account. He suffered no pain and there was no difficulty in swallowing. The left vocal cord was in the cadaveric position. Stringent applications were made to the larynx and strychnia was given internally. After about six months the movement of the right vocal cord compensated for the left cord, which was immovable. As the external swelling was growing, a surgeon saw the man and advised aspiration and the injection of iodine. As the result of this there had been a transient edema of the aryteno-epiglottical fold. Shortly afterwards he had been operated upon by Dr. Gerster. Lately there has appeared an ulceration and fungoid mass on the posterior third of the left vocal cord. The diagnosis made in the hospital had been malig-

nant papillary adenoma with carcinomatous degeneration. The man was at present in good general condition, though there was an increase in the size of the tumor, which is presenting in the lower pharynx.

Epithelioma of the Larynx Exhibiting Early Esophageal Symptoms.

Dr. James F. McKernon reported this case and presented the patient, a woman fifty-seven years of age. She had first come under observation on December 7, 1899. Up to two months previously her general health had been very good, but at that time there had been almost continual cough and marked hoarseness. The cough had then become paroxysmal, especially in the morning, the paroxysm being followed by the expectoration of much mucus and blood. On the morning of December 12th difficulty in swallowing had been noticed. This difficulty had steadily increased until now it was exceedingly difficult for her to swallow even a teaspoonful of water. The laryngeal examination showed marked swelling of the arytenoids, the commissure covered with glairy mucus, and to the left an ulceration about one-fourth of an inch in diameter, and also an infiltration of the esophageal opening at the lower pharynx. Examination by the pathologists showed a true epithelioma of the larynx.

The Destructive Effect of Inherited Syphilis.

Dr. Francis J. Quinlan presented a man, forty years of age, exhibiting the destructive effects of inherited syphilis. Up to the age of eighteen or twenty years there had been no symptoms, then he had suddenly experienced a soreness of the throat, and this had been followed by the expectoration of pieces of bone. Shortly afterwards there had been a violent spasmodic coughing spell, followed by complete collapse of the nose. Subsequently the man had married, and had had chancre. The case exhibited destruction of septum, bony and cartilaginous, with several perforations of soft palate and cicatricial adhesions of the lower faucial (post) fold to pharyngeal wall.

Epithelioma of the Larynx—Preliminary Tracheotomy.

Dr. Chas. H. Knight reported a case of epithelioma of the larynx in which a preliminary tracheotomy had been done with a view to performing the radical operation later. The patient was a man who was in a very precarious state from laryngeal stenosis before the trachea was opened, but since then he had been so comfortable that he had declined to submit to extirpation of the larynx. Meanwhile the neoplasm is steadily increasing.

A Case of Ulceration of the Inner Surface of the Cheek and Alveolar Process.

Dr. Knight also presented a case exhibiting an ulceration of the inner surface of the cheek, and involving to some extent the alveolar process. According to the history he had been infected with syphilis thirty-five years ago. He had been taking moderate doses of mercury and iodide for the past few weeks. The point of interest relates to differential diagnosis, whether the lesion be malignant, an ulcerating gumma, or a mercurial stomatitis. The rapid development of the ulcer and a negative microscopic examination would tend to exclude the first; the history would favor the second theory but for the fact that the breaking down of tissue occurred while the patient was under specific medication.

Dr. Jonathan Wright said that he had examined a piece removed from this case, and had found only a bunch of normal gland tissue.

A Case Presented for Diagnosis.

Dr. J. E. Newcomb presented a single man of forty years, who for several years had been employed as a hospital orderly. Eight years ago there had been hoarseness for a short time. In June, 1899, the hoarseness had reappeared after a cold. The lungs had been examined in August, and only slight high pitch respiration at the right apex in front had been found. The larynx showed an infiltration of the left vocal cord, and the latter moved sluggishly and did not quite approximate its fellow. On December 22, 1899, examination showed more pronounced infiltration of the left vocal cord, and an edematous condition of the corresponding arytenoid summit. He had first looked upon the case as tubercular, but now doubted this, and for that reason presented the case for diagnosis.

Case for Diagnosis.

Dr. Meierhoff presented a patient whom he had first seen in the latter part of 1896. The man is by occupation an instructor in vocal music. He complained of his voice. On examination all that could be found unusual was tumefaction of the right lingual tonsil. After a few months he had returned complaining of pain in the ear on the right side; there had been slight discharge from it, but nothing to indicate an active process in that ear. He had then lost sight of the man for four or five months. On his return he stated that he had an abscess opened in the dorsal region of the spine, and he was at that time wearing a plaster of paris jacket and a jury mast. In the fall of 1897 he had been unable to swal-

low, and examination showed that the site of the former swelling was then represented by an enormous slough. He had then been placed under Dr. Gerster's observation at the Mt. Sinai Hospital. After about a year the ulceration had yielded. Two or three weeks ago the man had returned complaining of pain on the left side, and on that side examination showed swelling of the lingual tonsil similar to what had been on the other side. Two days ago examination showed also a return of the tumefaction on the right side just as it had been in 1896.

DISCUSSION.

Dr. Wm. K. Simpson, referring to Dr. McKernon's case, said that the growth was distinctly extra-laryngeal in its nature, and from its appearance and the negative action of iodide there seemed to be little doubt about its malignancy. The case seemed to be inoperable.

Dr. Wendell C. Phillips concurred in the opinion that the tumor was extra-laryngeal because there was an entire immobility of the arytenoids and the vocal cords were perfectly normal.

Dr. J. Wright said that nearly all of the tumors of the posterior wall originate in the esophagus. Malignant disease of the larynx is very much more rare in women than men.

Dr. Simpson recalled two cases in which the symptoms were mainly laryngeal, and at the operation both the esophagus and larynx were found so extensively involved that the operation had to be discontinued. One of these cases had been under the care of Dr. Quinlan.

Dr. F. J. Quinlan remarked that he had seen four cases of malignant disease in this locality, viz., affecting the posterior laryngeal wall in females; the youngest was nineteen years and the ages of the others ranged between forty and sixty years.

Dr. Arthur B. Duel, referring to the cases of Dr. Knight, said that the first case had been an ideal one for laryngectomy at the time of performing the preliminary tracheotomy. The value of doing a tracheotomy some days or even some weeks prior to laryngectomy was well emphasized by this patient. The second case had not been long enough under observation, but it had been presented with the idea of determining whether the condition was due to syphilis, carcinoma or perhaps to mercurialism.

Dr. Jonathan Wright said that no doubt there was sufficient urgency in this case to justify a tracheotomy, but in the cases he had met with a preliminary tracheotomy had been a source of an-

noyance rather than a benefit. It interfered very decidedly with the dissection of the trachea and larynx from the posterior wall. Moreover, there was an additional risk from the tracheotomy itself. The advantage of the tracheotomy was but slight, especially when nitrous oxide gas was the anesthetic employed. With this anesthetic there was less shock and no mucus in the air passages; the only disadvantage was the blackness of the field of operation from engorgement of the vessels with venous blood. The second case looked to him to be one of ptyalism.

Dr. Lederman said that in the second case there was marked infiltration of the tongue which closely resembled syphilis.

Dr. Duel said that he had been under specific treatment for nearly six months. He had had three paralytic strokes and had been in consequence under specific treatment. He had received a large quantity of mercury.

Dr. Lederman, referring to Dr. Meierhoff's case, said that he had seen it a year ago, and at that time there had been a distinct ulceration. If the case was tubercular there should have been further extension of the disease by this time.

Dr. W. Freudenthal, referring to Dr. Newcomb's case, said that he had seen the patient seven years ago. Examination at that time had revealed acute laryngitis and bronchitis. These had disappeared quickly and had left behind a more or less edematous condition. There was no reason to believe the affection to be either syphilitic or tubercular. He could recall a similar case in a man thirty-two years of age, which had afterwards changed into pachydermia. This man had subsequently consulted a number of laryngologists in Berlin and Vienna, and they had all corroborated the diagnosis of pachydermia.

Dr. Quinlan said that he had seen a man two months ago in a similar condition. Repeated examinations of the sputum had failed to reveal any tubercle bacilli. He, however, persisted in giving a mixed treatment, and this lateral tumefaction of ventricular band entirely disappeared. Of course this swelling might have been only a coincidence, but in conditions of this nature it is always wise to give the patients iodide of potash.

Dr. Newcomb said that the man had not been treated systematically. No bacilli had been found in the sputum. He had had one slight hemorrhage. He was now on the iodide for the first time.

The Past and Present of Laryngology.

Dr. Orlando B. Douglas read a paper with this title. He said that much of the advance made in laryngology dated from the introduction of the laryngoscope by Czermak in 1858. One of the first in this city to learn the use of this instrument was Dr. Elsberg, who was the first to establish a free throat clinic, and to deliver, in 1861, the first course of lectures on laryngology in this country. The progress made in the past forty years had been largely due to the special study of the nature and causes of disease. In about eighty institutions of Greater New York diseases of the nose and throat are supposed to receive special attention. The author requested that in the discussion consideration should be given especially to the following questions:

1. What has brought you the greatest success in the treatment of diseases of the nose and throat?

2. What is the greatest—what do you most lack in the successful treatment of these diseases?

3. Along what line of investigation in nose and throat work promises the best results? The object being the relief of the greatest amount of human suffering.

Dr. Beaman Douglass said that this paper presented well the opportunities which were before the laryngologist. He would call especial attention to the facilities now obtainable in this country as compared with those abroad. Our hospitals and dispensaries gave advantages which could not be obtained abroad, particularly as to the matter of having beds for patients after throat operations. It was the rule abroad for the general surgeon to perform the larger operations on the nose and throat. This had been impressed upon him, especially during his stay in Vienna last summer. America was second to none in the matter of discoveries and advancement in rhinology; perhaps with the exception of sinus work our work here is superior to that seen abroad. To the questions propounded in the paper he would answer:

1. He had obtained the greatest success from the relief of obstruction. He had experienced the most trouble in relieving discharge.

Dr. R. C. Myles said that he had achieved the greatest success from the realization of the fact that relief of intra-nasal pressure and admission of air would give the greatest relief to the patient. The greatest need seemed to him to be a proper understanding of the action of the mucosa of the nose and the sinuses regarding the discharges which at present resist all efforts to control them. It

was probable that in the examination of pathological tissues and products substantial progress would be made. For example, if cases of malignant disease could be detected and treated quite early, the results would certainly be very much better than they are at present.

Report of a Case Illustrating the Importance and Possibilities of the Early Recognition and Treatment of Malignant Disease of the Larynx.

Dr. W. Kelly Simpson read a paper with this title and reported a case of a male, forty-four years of age, whom he had first seen on September 22, 1896. There was given a history of progressive hoarseness for the previous two or three weeks.

Dr. Wendell C. Phillips said that two years ago he had presented to the section what had been apparently a papilloma of the vocal cord, yet microscopical examination had shown it to be a true epithelioma. That man had been operated upon, and when seen recently he was in perfect health. With the one vocal cord he was able to speak distinctly enough to be heard in a room of fair size. This was but another instance illustrative of the importance of early diagnosis.

Dr. Charles H. Knight said that, given a unilateral lesion of the larynx in a patient past middle age, with a husky voice, the presumption was that the disease was malignant. Dyspnea, dysphagia, pain, hemorrhage, glandular infiltration are rather late symptoms, and when present usually leave no doubt as to the nature of the condition. He recalled having seen a case about one year ago in which the diagnosis of epithelioma had been confirmed by the microscope. A preliminary tracheotomy had been done, and the relief had been so great that the man left the hospital without submitting to the radical operation. When seen recently the trachea tube had been removed, and his voice was much better —indeed, the evidence of malignancy was by no means marked at the present moment, in spite of the microscopical diagnosis that had been made. Dr. Knight said that he was uncompromisingly opposed to complete laryngectomy. When malignant disease of the larynx had progressed to a degree necessitating such radical procedure, the condition is well-nigh hopeless. The risks of the operation itself and the chances of recurrence are undeniably greater the more extensive the disease. In certain cases of circumscribed disease he would advocate a laryngo-fissure, with free exposure, and removal of the parts affected if the framework of the

larynx were not involved. On the other hand, the possibilities of endolaryngeal surgery must not be forgotten. B. Frænkel had reported nine cases treated by the cutting forceps and snare with five remarkable successes, one of his patients being still alive after a lapse of fifteen years.

Dr. Wright said that he had made a pretty positive diagnosis of benign papilloma in Dr. Simpson's case. Microscopists showed a tendency to make a diagnosis of malignancy, because the border line between epithelioma and stroma were confused. Personally he had never felt justified in making a diagnosis on such grounds; he wanted to see the cells already growing in the lymph spaces. His refusal to make a diagnosis of malignancy in such cases as these had served him well in a number of instances. It was a very serious matter to make a positive diagnosis of epithelioma, particularly when the growth involved the larynx. Even tracheotomy was a menace to life. Frequently the microscope would fail one, and occasionally it would deceive. In his opinion, the larynx presented the most favorable spot for the eradication of malignant growth, because the presence of a new growth on the vocal cords gave rise to hoarseness and led the person to seek advice quite early. In these cases every means should be exhausted to make the diagnosis at once. Where proper treatment was instituted early the statistics were already very encouraging. He regretted to have to differ with Dr. Knight regarding total laryngectomy, yet he believed that where the disease was still confined to the larynx, even though on both sides, it was a proper case for operation unless the patient was in an extremely bad condition. He would admit that the statistics were bad, but such a procedure offered the only hope of prolongation of life and alleviation of suffering.

Dr. W. Kelly Simpson said that our hope was chiefly in the early recognition of the disease, and the larynx certainly offered prospects of success in this line. He was absolutely opposed to total extirpation of the larynx. He had been a party to four extirpations of the larynx within a comparatively short period, and all of these patients had succumbed within a week from foreign body pneumonia. These operations had been done by experts.

ERRATA.

On page 99, February LARYNGOSCOPE, second line from the bottom: "would cause an acute iritis" should be: "would cause infection."

THE LARYNGOLOGICAL SOCIETY OF LONDON.

Fifty-Third Ordinary Meeting, December 1, 1899.

F. DE HAVILLAND HALL, M.D., President, in the Chair.

A Diagnostic Mistake.

By Sir Felix Semon. On October 18, 1898, I was consulted by Mr. A. W., æt. thirty-nine, on account of soreness of the throat on the right side, about the level of the larynx, limited to one definite spot. He also stated that his voice had become gruff, and that swallowing, particularly of his saliva, was somewhat inconvenient. He had not brought up any blood and stated that he had not lost flesh.

On examination the pharynx was healthy, but the right vocal cord was fixed in about the cadaveric position, and the mucous membrane over the right arytenoid cartilage and the adjoining portion of the plate of the cricoid was considerably tumefied. There was no definite evidence of new growth and no ulceration. On phonation the left cord crossed the median line.

Externally there was general fulness of the glands below the anterior belly of the sterno-mastoid muscle, and this region was more tender on pressure than the corresponding part on the left side. There was a somewhat indefinite history of a chancre many years ago, apparently not followed by any secondary symptoms, although the patient had never been properly treated for it.

I gave him iodide of potassium in ten-grain doses for a fortnight, after which time I wished to see him again.

On the occasion of his second visit no improvement was noticed; on the contrary, the laryngeal tumefaction had increased, and the glands on the right side of the neck were distinctly larger and harder than they had been before. The patient also complained about increased pain in swallowing, sometimes shooting into the right ear. The iodide of potassium was increased to twenty grains three times daily, and the patient was told to come again in a fortnight's time.

When he saw me for the third time, on November 18th, matters were again worse than before. Still no ulceration was visible in the larynx, but the tumefaction had increased, and he was now very hoarse. The pain in swallowing had also become worse, and there was more swelling of the glands in the anterior triangle than before.

It seemed practically certain that one had to do with infiltrating malignant disease of the larynx. The removal of a fragment for microscopic examination was impossible owing to there being no distinct projection, but only general tumefaction.

As the question of operative interference became urgent, I sent the patient to Mr. Butlin for an independent opinion. Mr. Butlin shared my conviction that the disease was malignant, as also, I understand, did Dr. StClair Thomson, whose independent opinion the patient sought.

Although, on account of the extensive glandular swelling in the neck, I did not think the case a very suitable one for radical operation, still I felt it my duty to lay the alternatives of letting matters go on or attempting a radical cure before the patient, who decided in favor of operation.

I had a consultation with Mr. Watson Cheyne, who also did not consider the case a favorable one; but felt sure that if any radical operation were attempted at all, it ought to be complete laryngectomy. The patient consented to this.

On November 26th, in the presence of Dr. Lambert Lack and of myself, Mr. Watson Cheyne commenced the operation. In making the initial incision for tracheotomy, he came at once across an enlarged and apparently infected gland, in the middle line, quite distant from the region in which one would have previously anticipated that infection might have taken place. Other enlarged glands were detected immediately afterwards, which seemed to come through the crico-thyroid membrane. Tracheotomy having been performed, and a cut joining the tracheotomy incision having been made parallel to the border of the lower jaw, a number of small glands, apparently infected, became visible immediately, almost along the entire line of the incision.

Under these circumstances I urged that it was hardly worth while going on with the more serious operation originally contemplated, and Mr. Cheyne agreed with this view. The operation was therefore abandoned, but the tracheotomy tube left in position. So far as one could judge with the naked eye, the glands appeared epitheliomatous; unfortunately no microscopic examination was made.

The patient quickly recovered from the tracheotomy, and returned home a fortnight after the operation.

On October 24th of the present year, Mr. W., whom both Mr. Cheyne and I had supposed to have long since succumbed to his illness, suddenly called on Mr. Cheyne, looking very well, and

saying that he had been gaining flesh and strength. He told him that the glands in the neck had continued to enlarge after the operation, but had gone down a month or two afterwards. He had been taking "Clay's Mixture" (a preparation of Chian turpentine). His voice was still somewhat hoarse, but strong. He was still wearing his tube, but wanted to have it removed, if possible, this being the reason he had gone to see Mr. Cheyne. There was no difficulty in breathing without the tube, and the difficulty in swallowing had entirely disappeared. Nothing in the shape of glands was to be felt in the neck.

Mr. Cheyne wished me to see the patient with him, and a consultation took place on October 27th of this year.

The patient looked better than I had ever seen him before, and stated that he had gained thirteen pounds in weight since last year. His voice was good and strong; he wore the tube with de Santi's speaking apparatus. No glands could be felt externally, the right vocal cord was still fixed as before, but the tumefaction on the right side of the larynx had quite disappeared.

I put this case on record because it seems to me to teach the important lesson that, even under circumstances such as I have described, and which practically seemed to leave no doubt as to the nature of the disease, a number of experienced observers may be mistaken, unless indeed it be assumed that the disease had after all been epithelioma, and that it had been cured by Chian turpentine.

What the real nature of the disease was can even now, I think, hardly be stated with absolute certainty. What seems most probable, however, is that, after all, there had been a syphilitic perichondritis of the larynx, in the course of which an extensive but purely inflammatory swelling of the cervical glands occurred, and that whilst the laryngeal affection for some unknown reason had not yielded to the iodide, later on it had spontaneously subsided, followed by reduction of the glands to their normal size. Other causes, such as a so-called "idiopathic" or tubercular perichondritis, do not seem to come into question here.

The President expressed the opinion, which he was sure was unanimous, that Sir Felix Semon had done a very kind thing in bringing this case before the Society; an example which they might all follow with advantage, for they certainly learned more from mistakes than from anything else. As regards the cause of the great improvement, the man himself was firmly convinced that it was due to his mixture. Chian turpentine had a reputation at one

time, and there might after all be something in it. It reminded him of a similar diagnostic mistake in a different part of the body. He had a clergyman with chronic jaundice in the Hostel of St. Luke. His colleague, Mr. Wm. Rose, and he proposed to the patient that he should be examined surgically, to see if the obstruction could be removed. Mr. Rose accordingly opened the abdomen, and found a hard mass which he regarded as malignant disease of the liver. He (the President) was present at the operation and agreed with him. The patient was sewn up, and left the hostel in two or three weeks. Six months later he wrote to say he was completely well and had remained so since the operation. There is another example in which an incision is followed not immediately by improvement, but improvement some time later; he referred to tubercular peritonitis. He would therefore suggest that possibly the incision in the neck had something to do with the improvement.

Mr. Butlin said: I saw this patient in consultation with Sir Felix Semon, and came to the conclusion that the disease was probably malignant, not so much on account of the appearance of the larynx as because of the enlarged gland at the angle of the jaw. It is a very unfortunate circumstance that the glands which were taken out were mislaid, so that no microscopic examination of them was made; for we very much need more knowledge of the real nature of these diseases which disappear spontaneously, and which yet have many of the characters of malignant disease. It is, of course, almost certain, but it is not actually proved, that the disease in this case was not malignant, and that the diagnosis was erroneous. As to the mere error in mistaking an innocent affection for malignant disease, I have seen that mistake made so frequently by the best surgeons that I have long ceased to think seriously of it. And in many of the cases the disease has been so situated that it could be easily handled and closely examined. What wonder, then, if errors of diagnosis are made now and again in regard to tumors of the larynx which cannot be reached with the fingers, and which are only seen in the distance in a looking-glass. The wonder is, not that mistakes of diagnosis are occasionally made, but that the diagnosis is so frequently correct. I suppose no disease is so frequently mistaken for malignant disease as syphilis; and I have often said that iodide of potassium has cured more reputed cancers than all the quack medicine in the world.

Dr. StClair Thomson said it might interest the members if he read his notes of this case, as the patient consulted him a little

over a year ago, and as he did not mention that he had been under the care of any colleague the notes had the value of being uninfluenced by any suggestion. He found on the 19th of November, 1898, that the patient was slightly hoarse, had slight dysphagia, and no cough but some irritation in the throat. There was an enlarged hard gland below the right maxillary angle. The laryngeal mirror revealed a tumor of the right arytenoid, irregular, not ulcerating, concealing the greater part of the glottis, but the right cord on phonation was evidently fixed. The left cord moved easily. There was no loss of weight; no history of lues. The heart and lung sounds were normal. The patient was advised to take iodide and mercury for a week, when the question of operation would have to be considered. The patient then withdrew from Dr. Thomson's study, and the patient's brother proceeded to show such an intimate acquaintance with thyrotomy, iodide of potassium, extirpation of the larynx, etc., that he was charged with having seen other medical men about his brother. He confessed that the patient had been under Sir Felix Semon's care for the past five weeks, and that he had also seen Mr. Butlin. He was thereupon advised to return to their care and be guided by their advice.

Dr. StClair Thomson had not seen the patient again until he was shown at the meeting. In connection with this curious case, Dr. StClair Thomson said he would venture to refer to another, as it was not probable that he would be able to bring it before the Society. It was that of a poor professional man, æt. forty-eight, who was sent to him for loss of flesh, and dysphagia of three or four weeks. The left arytenoid region was occupied by an irregular, dull red growth, with white necrotic-looking patches on it, something like the snowdrifts in the hollows of high mountains. The speaker believed that Sir Felix Semon had referred to unusual snow-white appearance of tumors as pointing strongly to malignancy. Gleitsmann had also referred to the very white appearance in a laryngeal growth of unusual character. In Dr. Thomson's case there was much pain and discomfort from the constant tendency to swallow mucus. The cord on the same side was partially hidden, but was seen to move, while the right cord was normal. A gland was felt to be slightly enlarged on the affected side. There was no specific history. Under these circumstances a very gloomy prognosis was given, and indeed the patient's attendant in the provincial town where he lived was written to to be prepared for tracheotomy. Happening to be in the same town a month later Dr. Thomson had asked to see the patient, and found his voice

clear, his swallowing easy, and the growth entirely disappeared with the exception of a slight thickening of the left aryepiglottic fold. The cords were clear and moved freely. This improvement had taken place without the administration of any antispecific, or any particular line of treatment.

Mr. Spencer asked, respecting the two enlarged glands seen on the crico-thyroid membrane, one on each side of the middle line, were these glands frequently seen? He had seen the two glands enlarged in an undoubtedly syphilitic patient, who had first been treated by iodide of potassium and mercury, but who had afterwards to be submitted to thyrotomy in order to clear out the interior of the larynx. These glands might have been considered malignant to the naked eye had not the diagnosis of syphilis been certain.

Sir Felix Semon, in replying, said, with regard to the remarks of the President, that he also had seen cases of tubercular peritonitis get infinitely better, although not entirely cured, after opening the abdomen. He hardly thought, however, that such an explanation would apply to the present case, the less so, as only a very small number of enlarged glands had been exposed to the air in the course of the operation. He certainly was not a believer in the efficiency of Chian turpentine in cancer. With regard to Dr. StClair Thomson's observation, he begged to disclaim all responsibility for the description of certain forms of laryngeal cancer as similar to a "snowdrift." What he had said in reality was: that if one met with a growth of particularly snow-white color, which at first sight looked like a papilloma, but the eminences of which were not nearly so bulbous and rounded as in papilloma, but *sharply pointed* like grasses, that such an appearance was extremely suggestive of malignant disease. With regard to Dr. Spencer's remark, he thought glands existed near the crico-thyroid membrane on both sides of the trachea.

Case of (?) Myxofibroma of the Post-Nasal Space.

Shown by Dr. FitzGerald Powell. The patient, a boy æt. seventeen, states that he always had good health until four years ago, when he began to sleep badly at night, and as soon as he went off to sleep he was awakened by a feeling of suffocation. He had also at this time attacks of free bleeding from the nose and mouth, which occurred about twice a week. This got gradually worse. Two years ago he went to St. Bartholomew's Hospital and was an "in-patient" for six weeks. He states he had a swelling in his throat

which was lanced, but not otherwise dealt with. For over two years he has been unable to breathe through his nose. The growth grew pretty quickly about two years ago, but the patient does not think it has grown of late. Since the nose has been completely blocked he has not had any bleeding, but has suffered from great drowsiness, and has had incontinence of urine for two years.

On examination the naso-pharynx is seen to be full of a somewhat soft reddish-white growth, resting on the soft palate and pushing it forward, but not extending below the free edge of the palate. It is lobulated, movable, and is free posteriorly and at each side.

On pushing the finger along the front of the growth it appears as if its point of origin can be felt. It seems to be firmly attached to and to be continuous with the posterior end of the septum, which appears to be pushed to the left.

The right choana is roomy and filled with a prolongation of the growth, which can be seen from the front.

Dr. Herbert Tilley thought the growth was of a sarcomatous nature. It was soft, very vascular, with an extensive attachment, points which he had been enabled to determine satisfactorily by examining the growth with the finger in the post-nasal space. He advised removal, and in view of the difficulties which might be encountered at the time, especially free hemorrhage, a preliminary laryngotomy or tracheotomy would be advisable. The soft palate should then be divided, and the growth fully exposed to view, so that there could be no difficulty in dealing efficiently with its attachments, and the whole treatment would be rendered easier.

Mr. Spencer did not think this case malignant, but some of these growths tended to burrow extensively outward into the neighboring sinuses and fossæ. In a recent case he had found such a growth extending outwards behind the upper jaw into the temporo-malar region and cheek. It had been successfully removed from the face by cutting away the outer wall of the nose and antrum without disturbing the orbital plate or the alveolar border and hard palate. He did not see the necessity of tracheotomy if the parts were well exposed, a sponge drawn upwards into the naso-pharynx, and the patient well propped up.

Dr. Scanes Spicer said, as far as one could see from a cursory examination, this was not likely to be a malignant tumor. He had seen many similar cases, which were like modified polypi. A more careful examination was necessary, and, in his opinion, the growth should be removed by means of a snare. He called attention to

the large space between the soft palate and the spine, which would render possible almost any manipulation without dividing the palate in this case. He agreed with the name the exhibitor had given to the case—myxofibroma.

Mr. Butlin said: The tumor in this case, from its large size and red surface, appears to me to be probably a fibroma, and may probably be removed with safety. I have had a considerable experience in the removal of these post-nasal tumors, and have long since come to the conclusion that by far the safest and most certain method is to divide the soft palate and the soft parts of the hard palate in the middle line, and cut away the bone of the hard palate until the tumor is thoroughly exposed. I am very much opposed to temporary resection of the upper jaw and other methods practiced through the nose. Nor do I find it necessary to perform tracheotomy. The patient should be laid on his side, with the head forwards and low, the mouth well opened with a gag, and the light reflected from a head lamp or mirror. When the surface of the tumor has been thoroughly exposed, and its attachments have been ascertained, it can be freely cut out with scissors, chisel, and bone forceps. The hemorrhage is often very severe in such cases, but it can be arrested by plugging with gauze if it does not cease spontaneously. The removal of the tumor in this manner is not likely to be followed by recurrence of the disease.

Mr. Symonds said he thought that in a great many of these cases it was unnecessary to perform so large an operation as that proposed. He thought in the great majority of young people these fibromata could easily be removed from the mouth, while the smaller ones could be extracted through the nose. He had on several occasions dissected them from their adhesions by the finger introduced from the naso-pharynx, and sometimes from the nose at the same time. While the hemorrhage was for the moment smart, he had never encountered any difficulty in arresting it immediately by a plug in the naso-pharynx, this plug being removed before the patient left the table. He thought the hemorrhage in this case did not indicate any special vascularity. He had noted that there was not uncommonly an adhesion between the tumor and the pharyngeal wall, which bled freely on being torn. In recent instance this hemorrhage led a surgeon of distinction to abandon a case which was successfully dealt with in the manner described. He would, therefore, reserve the larger operation for those cases where the tumor grew into the neighboring fossæ. He would call attention also, on

the point of recurrence, to the fact that the mass removed on the second occasion might be a growth from a considerable mass left behind, and yet be of a simple nature. In one such instance he had at a second operation removed a process from the sphenoidal sinus.

Dr. Bond recommended that the growth be attacked through the mouth, which would not be difficult. The soft palate should be split, and thick pieces of silk should be passed through the sides of the palate and used as retractors, so as to afford a good view of the whole thing before chiselling away part of the hard palate, if that should be necessary. He was a strong believer in laryngotomy in operations on fibroids and sarcomata in the naso-pharynx, and recommended that a small sponge, fixed on the middle of a piece of tape, should be pulled down into the top of the larynx. Thus ample room was afforded the operator in the mouth and pharynx; he was not incommoded by sponges or chloroforming impedimenta; the chloroformist could do his work at ease, and any severe hemorrhage could be readily treated. The laryngotomy wound was a trivial one, and healed in two or three days.

Dr. StClair Thomson referred to a paper by Doyen, who had operated on a considerable number of these cases, and who had come to the conclusion that they should be attacked from the mouth. Doyen's great point was that the operator should push through quickly with the removal, regardless of the abundant hemorrhage, for the latter ceased rapidly as soon as the growth was completely detached. For the operation itself specially adapted raspatories were advised. Dr. Thomson also suggested the adoption of the Trendelenburg position for operations of this character.

Dr. FitzGerald Powell, in replying, said he was glad his case had given rise to such an interesting discussion, and he thanked the members for the remarks they had made and for the information he had derived from them. In connection with the treatment to be adopted, he thought the first point to be settled was as to the character of the growth; was it a pure fibroma, a sarcoma, or, as he believed, a myxofibroma? If the latter, its presence should not be attended with such serious consequences, and it was not so prone to invade the antrum, orbit and other parts as the pure fibroma or sarcoma. It was softer and grew more rapidly than the fibroma, but not so rapidly as the sarcoma. So far as he could make out it was not attached to the "basi-occipital" bone. His own feeling with regard to the operation was that it would most likely be successful, and his intention was to do a preliminary laryngotomy

then split the palate and examine the tumor and its attachment thoroughly, and if necessary, lift the periosteum from the hard palate and chisel away as much of it as was required to expose the origin and facilitate its removal. He hoped to show them the growth at a later meeting.

Case of Recurrent Papillomata of Larynx.

Dr. Bronner (Bradford) showed sketches of a case of recurrent papillomata of the larynx before and after the local use of formalin. A man of forty-nine had been treated for papillomata for several years, and a large number of the growths had been removed by forceps every two or three months. Various local remedies had been tried. A formalin spray was used for three months, and the growths had to a great extent disappeared, and there had been no recurrence during the last nine months. The spray was now used only one day in the week.

The papillomata were large, finely divided, of cauliflower appearance, and sprung from the vocal cords, ventricular bands and interarytenoid fold. They frequently gave rise to severe attacks of dyspnea. After the use of formalin the papillomata became much smaller and round; the finely pointed excrescences had disappeared altogether. The ventricular bands were nearly normal, but the vocal cords were still irregular and thickened.

In reply to Dr. Dundas Grant.

Dr. Bronner said among other applications he had used salicylic acid, but it had not the slightest effect.

Dr. Bond asked the strength of the sprays used.

Dr. Bronner replied that he began with sprays of the strength of 1 in 2,000, but gradually increased this till he employed a solution 1 in 250 or even stronger. He would like to know if any other members of the society had had any experience of formalin.

Case of Acute Ulcer of the Faucial Tonsil.

Shown by Mr. Wyatt Wingrave. Married female, æt. thirty-two, was seen on Tuesday, 14th inst., when she complained of sore throat and painful swallowing of three days' duration. On examination a single ulcer about the size of a shilling was seen on the right faucial tonsil. The outline was sharply defined, edges red, while the base was of a grayish-white color, and the slough was readily removed by throat cusps, exposing a rough mammillated surface. The surrounding tissues were apparently normal. There was but very slight constitutional disturbance, temperature being 100·2°. There was no history of syphilis, but she had lost her

father and one sister from consumption. Two days later the ulcer was unchanged in appearance, and her only trouble was constipation of the bowels. On the 21st inst. the ulcer had quite gone, leaving a ragged depression in the tonsil.

Scrapings were examined and showed mono- and multinucleated lymphocytes, free epithelial squames, streptococci, staphylococci and numerous slender rods which stained faintly with methyl blue. There was no tubercle, nor Klebs-Löffler bacilli. The history, clinical signs and the microscope having enabled one to exclude syphilis, diphtheria and tubercle, it was diagnosed as acute ulcerative tonsillitis, since it conformed in all respects with the classical description of Moure.

Mr. Lake exhibited a case two years ago, and described a special braded form of bacillus as predominating. In this instance the slender pale staining rods were the most numerous.

Case of Paresis of Soft Palate.

Shown by Mr. Wyatt Wingrave. A married man, æt. thirty-four, had complained of pain and a sense of constriction in his throat for four weeks, and of a change in his voice of one week's duration.

He stated that he had syphilis fourteen years ago, and had enjoyed fair health till a month ago, when he became short of breath, had attacks of giddiness and headache occurring frequently. He noticed that he was gradually losing control over his bladder, and his knees gave away. Later still food returned through his nostrils and his voice became nasal. Deglutition was painful.

On examination the soft palate was markedly paretic, and he evidently swallowed with difficulty and could not pronounce his gutturals. The vocal cords were normal in color and texture, but abduction seemed sluggish. Although the eyeballs were somewhat prominent, paresis of the ocular muscles was not observed, nor of the facial or lingual. Sensation and reflexes were normal.

He was at once ordered five-grain doses of potassium iodide, and in the course of three weeks has shown marked improvement, although the palate is still paretic and his voice still somewhat nasal in quality. Deglutition is painless and normal.

The President said the patient had had some difficulty in swallowing, together with a very sore throat, and as diphtheria seemed to be excluded by the absence of the knee-jerks, he would suggest that it was a local neuritis due to the inflammatory condition of the patient's larynx.

Growth of Granuloma of the Epiglottis for Diagnosis.

Shown by Mr. Waggett. The case of a robust man of sixty, complaining merely of slight hoarseness of four months' duration, sent to the hospital for removal of a papilloma of the uvula. Laryngoscopic examination showed an epiglottis much curled, deflected to the right and concealing the vestibule of the larynx. A mammillated excrescence was to be seen projecting from the posterior surface of the epiglottis near its right border. This excrescence had been white in color at first, but had on a later examination appeared purple. The posterior part of the right arytenoid region could be seen red, swollen and immobile during phonation; no glands in the neck. No evidence of pulmonary tuberculosis. One brother died of phthisis. A history of gonorrhea. After fourteen days' exhibition of potassium iodide the patient expressed himself as better, but the laryngoscopic image was unaltered.

Digital examination was not feasible.

Case of Esophageal Pouch.

Shown by Mr. Butlin. I show here the fifth pouch which I have removed from the esophagus. Like all the others, it was situated at the junction of the pharynx and esophagus, and projected on the left side behind the esophagus. The symptoms had been noticed for about eighteen years in a female fifty-nine years old, and were the typical symptoms of pressure-pouch; return of particles of undigested food a day or more after they had been swallowed; escape of gas and food on pressure; the absence of wasting, and the impossibility of passing a bougie further than about nine inches from the teeth. There was no actual bulging in the neck. The operation presented peculiar difficulties on account of the large size of the pouch and consequent deviation of the course of the esophagus. On this account it was exceedingly difficult to pass an instrument into the stomach, even when the pouch was exposed in the neck, separate from its attachments and drawn upwards. This was, however, accomplished before the pouch was cut out.

The patient is now convalescent. The result of the five operations have been four recoveries and one death. I think, if I had had the experience of this case before I removed the pouch in the fatal case (the third in order), that I should not have lost the patient. I probably should not have proceeded to take the pouch out after exposing it, as I could not, even then, pass any instrument into the stomach. I look on that as a necessary preliminary to the safe removal of an esophageal pouch.

Case of Double Abductor Paralysis under Treatment by Intra-muscular Injections.

Shown by Dr. Pegler. H. H., forty-four, married, and in very good general health, came to the Metropolitan Throat Hospital in June, 1899, complaining of loss of voice and some difficulty in breathing on inspiration, especially when hurrying. The voice was strident and disagreeable, but not aphonic. He admitted having had chancres at the age of twenty-two, when he was put through a mercurial course. On examination the vocal cords were seen in the cadaveric position, or, if anything, rather nearer the middle line, and they remained so on deep inspiration, the right cord abducting rather more than the left. On phonation they abducted slightly. A small conical projection was visible in the interarytenoid space. The biniodide was administered freely by the mouth; in about ten days the small growth disappeared, and the patient felt much benefit both as regards breathing and voice. About a month ago, following the example of my colleague, Mr. Lake, I began and have continued using intra-muscular injections of perchloride, 1 in 120. The cords now move if anything a little better, and the patient insists that there is a still further improvement in his voice. He prefers the injections in every way. About 20 mins. of the solution are injected into the buttock twice a week.

A Case of Tubercle of the Larynx.

Shown by Mr. Charters Symonds. The patient, a woman æt. forty-eight, came to the throat department at Guy's Hospital in October last, complaining of loss of voice. The left ventricular band and cord were occupied by a deep red, firm infiltration, extending the whole length. In the center was a depressed, irregular grey surface with raised edges. There was slight mobility of the cord and arytenoid, the appearances closely resembling those of malignant disease, more especially as the arytenoid was quite normal, and there was a total absence of the gelatinous infiltration commonly seen. At this stage the diagnosis of malignant disease presented some difficulty. To remove any doubt, a portion from the center of the ulcer was removed, and proved microscopically to be tubercular granuloma. Subsequent to this a history of hemoptysis some years previously was obtained. No disease was found in the lungs.

At the present time the appearances resemble closely those above described, except that the gap in the center is larger, on account of

the operation, and the cord is slightly more movable. The patient is pale and thin, and exhibits signs of pulmonary trouble.

The object of showing this case is to mark the resemblance of this form of tubercle to that of epithelioma. Recognizing that tubercular tumors may remain with little alteration for considerable periods in the larynx, and thus closely resemble malignant disease, I brought this patient to illustrate that point. I may add that in a recent case the solid tubercular growth was sufficient to occlude the larynx. In this case there was no ulceration, no expectoration, none of the gelatinous swelling; in fact all the appearances closely resembled carcinoma.

Dr. Clifford Beale asked whether there had been any obstruction of the larynx before the piece was removed? He thought that in cases of submucous tubercular infiltration without breach of surface, the swellings might remain for long periods without change or even with diminution. He had shown such cases at previous meetings, and in one instance, under observation for five years, the patient had died, and the larynx showed that there had been no real obstruction and no breach of surface. After removal of a part of the swelling a raw surface must remain, as in the present case, and if the patient happened to be bringing up tubercle bacilli in the sputum there was danger of reinoculation.

Rhinolith.

Shown by Mr. Charters Symonds. The specimen shows a calcareous laminated wall enclosing a cavity. When recent, this cavity was occupied by some soft grumous material, which may have been an old decolorized blood-clot or some inspissated mucus. It was removed from a boy æt. eleven. He had had a cold for a couple of months, and it was noticed in the later stages that the discharge was confined to the right side and had become sanguineous. The rhinolith was removed by a probe. There was no history whatever of the introduction of a foreign body, nor was there any evidence of old disease in his nose. He was the son of well-to-do parents, and therefore had not been neglected.

The object of exhibiting the specimen is, first, to show its peculiarities, and, secondly, to note the short duration of the symptoms caused by a foreign body which must have existed for some years. That this must be the common history in such cases is well known. In another instance, where a friable calcareous mass was removed, the symptoms were also of short duration, but here there was a history of the introduction of some rose leaves into the nose six years previously.

Case of Tertiary Specific Ulceration of the Ala Nasi.

Shown by Dr. Dundas Grant. The patient, a married woman æt. thirty-six, came under my care on the 23rd of the present month on account of an ulcer on the right ala of the nose of about two months' duration. The ulcer was about the size of a sixpence, and in the center there was a small portion of tissue which appeared to be true skin, but infiltrated. The ulceration furrow around this was deep and the edges considerably thickened and infiltrated.

It had first appeared six months previously to my seeing her as a white speck followed by spreading ulceration, but had healed up under the action of medicine, presumably iodide of potassium. In the fauces there were cicatricial changes such as would result from tertiary ulceration involving the loss of the uvula.

Six years ago the patient suffered from a sore throat which lasted some weeks, and was accompanied by a rash and by loss of hair; and four years later she had severe ulceration of the throat. She had two children, the youngest of which is thirteen years old.

Presumably this specific affection dates about six years back.

Case of Tuberculous Ulceration of the Pharynx and of the Lower Lip.

Shown by Dr. Dundas Grant. J. R., aged forty-two, who looked much older, came under my care on the 23rd of the present month complaining of sore throat and cough, which had gradually developed during the last three months. The voice was husky, deglutition was painful, and the cough was accompanied by the expulsion of a yellowish-colored sputum tinged with blood. On inspection there was seen on the left half of the palate, uvula, tonsil and anterior pillar an extensive ulcer, which on the flat surfaces was very shallow, but owing to its dipping into the irregularity of the part appeared in some places to be excavated. It was pale and the floor was covered with dusky greyish granulations from which exuded a slight moisture. The edges were not everted, and there was no induration on palpation. There was a fiery red areola. There were unmistakable signs of tuberculosis in both lungs, especially the right, and the diagnosis was made of tubercular ulceration. A scraping, however, was not found to contain tubercle bacilli, but the examination will have to be repeated. The glands are scarcely perceptibly involved. On the lower lip there is a deeper ulcer with soft, slightly edematous edges, the base being covered by a yellowish scab, the condition being probably a secondary focus of tuberculous inoculation.

Case of Swelling about the Bridge of the Nose.

Shown by Mr. Waggett for Mr. Stewart. A boy of eighteen, exhibiting indolent swelling about the bridge of the nose and edema of the skin in both orbital regions, a condition very similar to that of the cases shown at the November meeting. The swelling commenced two years ago, and had been under observation now for eight months with permanent improvement. There was a history of a kick on the nose three years ago, and several blows had been received since.

Iodide of potassium had effected no change, and the same was to be said of the continuous application of the ice bag for ten days.

Ulceration of Alæ Nasi.

Shown by Mr. Charles A. Parker. The patient was a female, æt. twenty-two, who had suffered from ulceration of the nose for two years. It affected both alæ, but extended more on the right side than on the left, and there was considerable loss of tissue.

The diagnosis rested between syphilis and lupus, and the opinion of the society was invited as to which of these two troubles was the cause of the ulceration. The patient had been on potassium iodide for three weeks, but had not taken it with any great regularity.

The President: It struck me as lupus or chronic tubercle.

Dr. Dundas Grant: I should say lupus decidedly.

Dr. Lambert Lack: I should say syphilis.

Mr. Parker thought it rested between syphilis and lupus, and treatment alone would settle the question.

A Case for Diagnosis—A Boy æt. Ten Suffering from Aphonia.

Shown by Mr. Roughton.

Dr. Pegler thought the boy could scarcely be considered aphonic, as he had succeeded in making him speak in a fairly audible though feeble voice. With reference to treatment, he thought the fault lay perhaps as much with the respiratory muscles as with those of the larynx. He therefore recommended a course of exercises in breathing, as the boy exhibited deficient chest expansion, and his vital capacity was probably much below par. The speaker was directing his attention to this point in similar cases at the present moment, and in an extremely obstinate case of functional aphonia now under his care he found the breathing much at fault, the vital capacity being 80 in place of 150. The hope was that by remedying this defect the loss of coördination between the muscles of respiration and phonation would be restored, and there seemed some

promise of its fulfillment. In the boy's case the same plan was worthy of a trial, as in any case the exercises could but be beneficial.

The President concurred as to the advantage to be derived from exercises such as those mentioned by Dr. Pegler. He started regular systematic exercises of the chest in a patient, whom, however, he had not seen since. Sir Felix Semon had suggested it was much more of a spastic condition than an ordinary aphonia. He (the speaker) did not think the air current was sufficiently large to put the vocal cords into proper action.

Case of Tubercular Laryngitis in a Man æt. Thirty-One.

Shown by Dr. FitzGerald Powell. When first seen on November 16th he complained of loss of voice and some difficulty in breathing.

The patient enjoyed good health until five years ago, when he caught a severe cold and lost his voice; he has regained it somewhat, but it has been husky ever since. Two months ago the voice got worse. Twelve months ago he had an attack of dyspnea, but otherwise has not felt the breathing to be labored, though at night he is seen to have considerable stridor.

On examination the general appearance of the larynx is rather red; the glottis is little more than a chink. On the right side the arytenoid is fixed, and the cord is obscured by the false cord, which is drawn over it and is ulcerated. On the left the vocal cord is broad and thickened, and is covered with granulations. In the posterior commissure, rather to the left, there is a pedunculated growth, which flaps to and fro on inspiration and expiration.

His family history is good, and I can find no history of syphilis.

Signs of cavity and consolidation are found in the lungs, though no bacilli were found in his sputum on examination.

On November 29th, when he was last seen, he was much better, and the breathing during sleep quite free from stridor.

The right cord can now be seen beneath the ventricular band, the left cord is smoother, and there appears to be much more breathing space.

CORRESPONDENCE.

Editor THE LARYNGOSCOPE:—

On page 97 of the February issue of THE LARYNGOSCOPE, Dr. James E. Newcomb quoted me as thinking the suprarenal capsule extract has a "distinctly anesthetic action." I would like to call the doctor's attention to an article of mine, "Clinical Observations on the Use of the Aqueous Extract of Suprarenal Capsule in Operations Within the Nasal Chambers," in the *International Clinics*, p. 15, vol. iv, series 7th, 1898. He will find there that I say it "does not produce of itself any anesthesia, unless used in combination with and after the local application of cocaine or eucaine and then only on mucous surfaces." In the *American Journal of Ophthalmology*, August, 1898, an article entitled "The Use of Suprarenal Capsule Extract in Minor Eye Surgery," also asserts "the principle upon which its physiologic action depends is the contractile power of the extract upon the arterioles—a vaso-constructing action. Locally, its action is purely one of contraction."

Again, in the *La Parole*, Paris, France, June, 1899; also *Journal American Medical Association*, May 20, 1899. In another essay upon this subject, "Aqueous Suprarenal Extract; Its Surgical and Therapeutic Uses," I made the following statements: "It (the extract) has absolutely no action on the skin, nor does it possess any anesthetic properties wherever applied." I feel sure from the above quotations that Dr. Newcomb could ever in the future misquote me and I trust he will readily see that I have never stated in any of my articles upon the suprarenal capsule extract that the extract had the slightest anesthetic properties when applied locally or otherwise. Thanking you for above space,

I am, sir, gratefully yours,

Houston, Texas. JOSEPH MULLEN.

ABSTRACTS AND BIBLIOGRAPHY.

Arranged and Edited by

FAYETTE C. EWING, M.D., St. Louis,

with the collaboration of the

EDITORIAL STAFF.

It is our purpose to furnish in this Department a complete and reliable review of the world's current literature of Rhinology, Laryngology and Otology.

Authors noting an omission of their papers will confer a favor by informing the Editor.

I. NOSE.

Remarks on the Pathology of the Nasal Septum—JONATHAN WRIGHT—*Brooklyn Med. Journ.*, October, 1899.

Jacobson's organ is but rudimentary in the human being. It is situated about an eighth of an inch back of the column near the floor of the nose. It is lined with cylindrical epithelium, and though olfactory filaments are found among its cells, it is nevertheless functionless. According to Kisselback, the site of this organ in man is apt to be the seat of vasular swelling of the mucosa, and the origin of most of the nasal hemmorhages. In animals (like the sheep) this structure is very well developed.

The author calls attention to two masses which are often seen with the post-nasal mirror, and are located on each side of the septum near the posterior border where it articulates with the sphenoid bone. These swellings are frequently mistaken for bony projections, but are made up of erectile tissue. They often occur in patients suffering from hypertrophic rhinitis. After cocain is applied to these areas, the masses collapse and the space at this region is considerably increased. The close analogy in the anatomical structure of the erectile tissue of the nose and that of the genitalia is pointed out. Sexual excitement in man is often ushered in by sneezing. Vicarious menstruation is sometimes observed from the nares. "Masturbation in either sex is in adolescents a fertile cause of nose-bleed." "Bony cysts of the middle turbinals are seen almost exclusively in women during their sexual life."

True papilloma in the nose is nearly always found on the anterior part of the cartilaginous septum. Angrimatous growths are the most common of all benign growths of the nasal septum, and sarcomatous formations are frequently angrimatous.

Septal spurs and deviations are believed by the author to be due to hypernutrition, the result of an inflammatory process. This process usually starts in the mucosa covering the septum, and is frequently the result of some traumatism. Nature throws material along the area involved, and so produces the spur. LEDERMAN.

The Importance of Nasal Breathing in Early Childhood—R. E. Moss—*Texas Medical Journal*, November, 1899.

Defective nasal breathing in early life is an etiological factor in many ear and throat affections of later life. The cause may gradually disappear as in the case of adenoids which tend to atrophy after puberty, but the pathologic effects may be permanent.

W. SCHEPPEGRELL.

Hygiene of the Nose—W. CHEATHAM—*American Practitioner and News*, December 15, 1899.

The nose has a most important function to perform in preparing the air for respiration, and it is therefore of the greatest importance that it should be kept in a normal condition. The douche is dangerous, but the spray is a useful adjunct in treatment.

W. SCHEPPEGRELL.

Deviated Nasal Septum—G. T. ROSS—*Canada Med. Rec.*, Dec., '99.

This is a report of a clinical lecture, in which an able résumé is given of the latest views and operations of Asch, Gleason, Bosworth and others.

GIBB WISHART.

Rhino-Edema—H. H. CURTIS—*N. Y. Med. Journ.*, Dec. 16, 1899.

Dropsy of the nose may be due to a paresis, brought about by over-excitation of the vasomotor nerves, or by a direct injury to the nerves themselves, either by pressure or disease. Wuinewarter has shown that vessels in an inflamed part are more permeable than in healthy tissue, as pictured by the infiltrated welt in scratching an urticaria.

The author mentions a case of dropsy of the arytenoids, in a patient who drank large quantities of water. The disease was cured by reducing the quantity of water imbibed. He believes that many cases of so-called winter hay fever are cases of bone rhino-edema. Three types of cases are seen. The anterior, the posterior and general erectile irritations. A constant symptom of this affection is an intensified desire to breathe through the nose, amounting almost to mania. The disease is sometimes associated with sexual perversion.

The treatment advised is the use of the rectal sitz douche, with the nozzle in the center of the cusion, by which the patient may wash the entire colon morning and night with four quarts of water in which is put a spoonful of sea salt and sodium bicarbonate. In no way can venous stasis in any part of the body be so quickly relieved, as this method, together with general systematic exercise, has no equal in benefitting the portal circulation. Cocaine affords no relief in this condition. Strychnine and digitalis are given internally, alternating hot and cold douches to the spine are also recommended.

M. D. LEDERMAN.

Schleich's Method in Operations on Deviations and Ridges of the Septum—E. BAUMGARTEN—*Archiv. für Laryngologie*, Band ix, Heft 3, 1899.

In dealing with these conditions the author has been greatly troubled by the hemorrhage which obscured the field of operation and often caused him to postpone the completion of the operation to a second or even a third sitting. Since adopting the infiltration method, however, he says that the operation is generally almost bloodless. The whole *terraine* of the operation is plainly in view and the anesthesia is even more satisfactory than that obtained from cocain. The solution used is as follows:

Sodii chloridi	0.6
Aqua distil	100.0
Eucain	0.2

The author says that this mixture produces ample anesthesia as well as a very complete ischemia. He advises first rubbing the mucous membrane with a 10 per cent solution of cocain, in order that the needle prick may not be painful. He then introduces the needle and injects above and below the crest if necessary; injecting enough to raise the mucous membrane, all about the lesion and turn it white.

One drawback to this method is the fact that a more profuse hemorrhage is liable to occur later on, and as a consequence of this the author has come to tampon the nose carefully as a routine measure after each operation.

However, he thinks that this disadvantage is more than compensated by the freedom with which one can operate when the field of operation is not obscured by bleeding. VITTUM.

On a Case of Nasal Hydrorrhœa—URBAN MELZI—*Journ. L., R. et O.*, December, 1899.

This obstinate disease was seen in a woman, forty years of age, who for six years, dating from a confinement, has been affected with a continuous and abundant discharge from the left nostril of a perfectly colorless liquid. It prevented the patient from doing any work. This fluid did not cause any excoriation of the nose or lip. According to the patient it was without taste. The clinical examination proved it to be alkaline; specific gravity, 1,009; absence of albumen. Globuline appeared to be the more important albuminoid. No morphilogical element was seen under the microscope. No sugar or peptone was discovered, but abundant chlorides were precipitated by the silver test.

Numerous squechiæ were seen in the nose from previous treatments. The sense of smell was comparatively unchanged. The only medication which afforded her relief was the introduction of a cotton pledget, moistened with a saturated solution of cocaine. This treatment she frequently applied herself. Though some benefit was derived from vibratory massage, the local and internal application of atropia, and the local application of a 5 per cent of protargol solution, the patient returned to *her original condition.*

M. D. LEDERMAN.

Treatment of Nasal Stenosis Due to Deflected Septum, With or Without Thickening of the Convex Side—JOHN J. KYLE—*St. Louis Med. Gazette*, December, 1899.

The importance of septum deflection as a possible cause of mental aberation is mentioned, and the author believes that the periodical examination of the eyes of school children should extend to the nose, throat and ear. Reviewing the different methods of operation, the author believes that that of Asch will be the most popular. He describes it, and advocates the use of suprarenal extract to prevent the profuse hemorrhage. The confinement to bed and long use of rubber splints, may, he thinks, detract from this method. EATON.

Hay Fever: Its Resorts, Victims and Their Late Conventions—Present Status of the Disease—JULIA W. CARPENTER, Cincinnati—*Lancet-Clinic*, December 23, 1899.

The essay gives an account of the last meeting of the United States Hay Fever Association at Bethlehem, N. H., in September. It was the twenty-fifth anniversary of that society, which was organized by Henry Ward Beecher and several distinguished sufferers. The consensus of opinion among the White Mountain resorters was that hay fever was not cured by "having their noses burned out." The germicide sprays had proved disappointing, but the writer cited a case in which sprays of the aqueous extract of suprarenal capsules (strength not mentioned) gave relief during the season, so that the patient was enabled to remain in New York city. The secretary of the association, a clergyman, claims that none of the thousands of hay-fever sufferers known by him has ever been cured.

The author inadvertently ascribes Oliver Wendell Holmes' cure for this disease to Mr. Beecher. The latter wrote to Dr. Holmes, asking if there was any cure for hay fever. Holmes replied: "Yes, gravel six feet deep." Carpenter believes that if this malady were as prevalent in Europe as it is in America "the problem would have been solved ere this" by the superior wisdom of European physicians.

In the discussion of this paper before the Cincinnati Academy of Medicine, B. Tauber mentions having treated many cases in Denver as well as in Cincinnati. His greatest success has resulted from tonic treatment, removal of hypertrophies and cauterization of sensitive areas in the nasal fossæ, correction of the uric-acid diathesis by lithium, hydriodic acid, etc., and the use of the "oily camphor-menthol sprays."

D. T. Vail called the essayist's attention to the fact that hay fever exists in Europe and England as well as in this country. Helmholtz was a sufferer, and wrote on the subject several decades ago. He thought he had caught the germ and had discovered the cure—quinine sprays. The first writers on hay fever were English physicians. Other speakers gave their views both favorably and adversely to nasal surgery and the uric-acid treatment in hay fever. BISHOP.

II. MOUTH AND NASO-PHARYNX.

A Case of Membranous Angina and Membranous Vaginitis of a Doubtfully Diphtheritic Nature Occurring in a Patient Convalescing from Scarlet Fever, and Associated with an Unusual Erythematous Eruption — C. KILLICK MILLARD — *Lancet*, November 11, 1899.

The questions of the nature of the rash observed in the case recorded, and the origin of the membranous exudation which occurred at the same time, are of the greatest interest. As to the membrane on the fauces, it is certain that in some cases of scarlet fever a membranous inflammation of the fauces occurs, not diphtheritic in nature. The case appears to be sufficiently interesting to justify recording. The clinical symptoms, apart from the peculiar erythema, were exactly those of faucial diphtheria following scarlet fever, with auto-infection of the vulva and vagina, and the improvement following the administration of the antitoxin and the subsequent albuminuria both help to confirm this diagnosis. On the other hand, it was certainly remarkable, if the case really was diphtheria, that no Löffler's bacilli could be found. The method followed in searching for them was the usual one, of which the author had had considerable experience, and he made repeated cultivations, about six or more, at different dates, some with actual membrane and some with swabs, but all with similar results. The constant presence, in almost pure culture, of *staphylococcus pyogenes aureus* suggests that it may have been the true cause of the condition, and may possibly explain the peculiar erythema. He has seen many adventitious rashes following scarlet fever, and many of purely septic origin, but has never seen anything quite like the one in question. The subsequent albuminuria may quite well have been a sequela of the scarlet fever and independent of the (?) diphtheria. STCLAIR THOMSON.

Aphthous Tonsillitis or Diphtheroid Sore Throat—MARK H. O'DANIEL—*Georgia Journ. of Med. and Surg.*, Nov., 1899.

The clinical history of a case which was probably diphtheritic and not aphthous. No urinalysis or bacteriological examination was made. W. SCHEPPEGRELL.

Sarcoma of the Carotid Sheath; Removal of the Growth, together with Portions of the Carotid Arteries, Internal Jugular Vein and Pneumogastric Nerve; Recovery—SCANES, SPICER AND STANSFIELD COLLIER—*Lancet*, August 5, 1899.

The description of this case could not very well be epitomized, and readers must therefore be referred to the original. It contains a valuable table of thirteen cases of tumor, in which operation involved sacrifice of all the structures contained in the carotid sheath. STCLAIR THOMSON.

Fibrous Tumor of the Pharynx—Sequel—E. FLETCHER INGALS—*N. Y. Med. Journal*, December 16, 1899.

A supplementary report of a case seen some years ago as a fibrous tumor in the naso-pharynx of a boy thirteen years old. An attempt to remove the growth was made at that time through an external operation, but the hemorrhage was so great that not much of the growth was removed, and the operation had to be stopped.

The growth continued to increase until the right nostril was completely closed, and the right malar bone became very prominent. He lost sight in the right eye. No treatment had been given. In the course of a couple of years the boy began to breathe better, until the close of nasal cavity was quite full again. The right cheek is growing smaller, after a period of fifteen years.

On examination after this time, the fibrous growth which formerly occupied the nose for four years, had disappeared. The eye, though in appearance normal, is blind. There was a large opening into the sphenoid cells into which the growth previously extended. M. D. LEDERMAN.

Tuberculosis of the Pharynx—C. F. THEISEN—*Journ. Am. Med. Assn.*, July 12, 1899.

Tuberculosis of the pharynx is a comparatively rare disease, occurring in only about 1 per cent of the cases of tuberculosis of the upper-air passages. It is usually, but not necessarily, secondary to tuberculosis in some other part of the body.

The combination of tuberculosis and malignant growths is mentioned.

Statistics are given to show the frequency of the tubercle bacillus in the tonsils and in adenoid tissue.

Two cases are reported illustrating the symptoms, course, termination and treatment of the disease. ANDREWS.

A Note on the Occurrence of Epithelial Pearls in the Tonsil—HUGH WALSHAM—*Lancet*, April 29, 1899.

The late Professor Kanthack,* in an interesting paper, called attention to the occurrence of epithelial pearls in the tonsils of human fetuses and new-born infants, and pointed out that they occurred as retentions and not as embryonic inclusions. Professor Kanthack, in a later paper, published in the *Journal of Anatomy and Physiology*, Vol. xxvi, brought forward weighty arguments against the pearls which are found in the mid-line of the palate, and in other places being due to inclusion products, as described by Mr. Bland Sutton in his lectures on Evolution in Pathology. The occurrence of these epithelial pearls in the tonsils of adults is not altogether rare, and while making some observations on the occurrence of tubercle in the tonsil the author met with three very good specimens in the tonsils of men aged twenty-seven, thirty-one and thirty-five years respectively. The occurrence of these pearls in

*Kanthack, *Illustrated Medical News*, November 9, 1889.

the organ is of interest, because there can be no doubt that they are the origin of at least some of the so-called tonsil calculi. The accompanying illustrations show very clearly these interesting bodies. The center of these pearls shows no definite structure; it is only on carefully examining the periphery that we see that they are composed of horney, squamous, epithelial cells pressed tightly together. They bear a very close resemblance to the epithelial cell nests found in some of the epitheliomata. These pearls are clearly retention products, and cannot possibly be due to epithelial inclusion, as no fusion of epithelial surfaces takes place in the tonsil. Their occurrence, as before said; is not altogether rare, but these are the only three examples met with out of 150 post-mortem examinations of tonsils made with reference to this point. Professor Kanthack once informed the writer that since 1889 he had fairly often observed epithelial pearls in the tonsils at all ages. But in addition to these retention pearls we find epithelial accumulations in the adenoid tissue of the tonsil which apparently has not before been described. They are mostly to be found in the center of one of the closed lymphatic follicles, and have no connection with the epithelium lining the tonsillar crypts. According to Professor Retterer,† both the ectoderm and mesoderm take part in the formation of the tissue composing the closed follicles of the tonsil. He says the tonsil is formed by epithelial involutions and swelling of the mesoblastic tissue, then by the formation and detachment of terminal epithelial buds. The closed lymphatic follicles are formed by the formation round these buds of lymphoid tissue. As life advances this central epithelial accumulation disappears. Specimens of tonsils from young persons show these epithelial accumulations in the center of the follicles. They cannot, therefore, be regarded as either retention or inclusion products, but the writer thinks that they are produced by the normal evolution of the organ.

StClair Thomson.

†Retterer: "Origine et Evolution des Amygdales chez les Mammiferes," *Journal de l'Antomie et de la Physiologie*, 1888.

Surgery of the Tonsil—Thos. F. Noland—*New Albany Med. Journal*, January, 1900.

Two conditions of the tonsil, the hypertrophic and the atrophic, are pathological. The hypertrophied tonsil by its pressure causes a constant irritation of the tissues of the throat and prevents the proper development and action of the palatal and pharyngeal muscles. Removal of the gland in this condition is demanded, if it projects beyond the palato-glossal fold.

The atrophied tonsil is equally deleterious by reason of the pressure of infection-retaining follicles filled by dried, decomposing secretions. The absorption into the circulation of this infectious material is a common cause of pains formerly called growing pains. Such follicles should be cleansed, split open and the ragged edges trimmed off.

Detwiler.

Fibro-Lipomatous Tumor of the Epiglottis and Pharynx—E. FLETCHER INGALS—*N. Y. Med. Journal*, December 9, 1899.

This growth occurred in a male, twenty-eight years of age. He complained of difficulty in breathing, speaking and swallowing.

On examination a large tumor was seen filling the laryngo-pharynx and apparently attached to the right two-thirds of the base of the tongue and to the right side of the pharynx. In attempting its removal with an ordinary polyp snare, armed with a No. 5 steel wire loop, the wire broke three times, so a uterine ecraseur, bent at a right angle, with a No. 8 piano wire, was employed. A number of pieces of the growth were removed, and the stump touched with the galvano-cautery.

The tumor was found to be attached to the upper portion of the right side of the epiglottis, the right pharyngo-epiglottic fold to the base of the tongue and to the right side of the pharynx. The microscopical examination revealed its structure.

The sequel of the operative treatment showed adhesions between the right side of the epiglottis and the pharynx and partly to the base of the tongue. No unpleasantness, however, was experienced by the patient. M. D. LEDERMAN.

Adenoids Neglected and some of the Results—M. H. GASTON—*Western Med. Review*, November 15, 1899.

The author enters an earnest plea for the early removal of adenoid growths. The family doctor, as the guardian of the health of the various members of his families, should be prepared to do this work, or at least should be competent to recognize the presence of the growths and send the child to a specialist.

D. W. DETWILER.

A Death from Leukemic Infiltration of the Upper Air Passages—ERNST HIRSCHLAFF—*Deutsche Med. Wochenschr.*, April 13, 1899.

At a meeting of the Society of Internal Medicine at Berlin, the author reported the following extremely interesting case. The disease, of course, belongs strictly to internal medicine, but the cause of death must be interesting to laryngologists especially,

The leukemia was pronounced and the patient had been under observation for some time. Suddenly the author was called to her as she was suffering from great difficulty in breathing. An examination showed the uvula enlarged to the size of the last joint of the thumb and of a snowy whiteness. The pharyngeal organs had often been examined before, but nothing abnormal discovered. The glistening snow-white discoloration of the mucous membrane spread into the pharynx under the examiner's eyes. In a few hours the left palatine arch was swollen to the size of the little finger. A little later the tonsil was involved. Soon a stridor developed, and the sufferer passed away with symptoms of laryngeal edema. The post-mortem, in fact, showed well-marked edema glottidis.

VITTUM.

III. ACCESSORY SINUSES.

The Negative Air Douche as a Means of Diagnosis in Diseases of the Accessory Cavities of the Nose — L. RÉTHI — *Wiener Klin. Rundschau*, October 22, 1899.

After a cursory glance at the ordinary diagnostic measures, the author speaks of the operative procedures, such as removal of the middle turbinal and exploratory puncture of the antrum. Many patients will not submit to these maneuvres when it is explained to them that they are to be done merely for diagnostic purposes.

In this case the negative air douche, as recommended by Seifort (see LARYNGOSCOPE, December, 1899, page 382), is often of great service. The author says that since he has begun to use negative Politzerization he is very rarely able to discover the presence of pus by probing when this new method has failed.

He advises that the negative air douche be made a routine measure in examinations, and that in no case should any operative procedure be undertaken before it has been tried. VITTUM.

Cephalagia and Tic Douloureux from Accessory Sinus Affection —S. F. SNOW—*Buffalo Med. Journ.*, January, 1900.

According to this observer it is generally conceded that there is no pain or neuralgia as a disease *per se*. He believes that in 75 per cent of cephalalgias, nasal disease or accessory sinus affections are the determining causes.

The condition of constant and severe pressure in these cases is sometimes due to an acute retention of mucus or pus, or due to a collection of polyps within the antrum, ethmoid or sphlenoidal sinuses. A few cases are reported in which the pressure symptoms were relieved by intra-nasal treatment. In one of the cases the symptoms were suddenly relieved by the breaking through of a nest of small pale tumors in the upper nasal fossa, from the ethmoid cavities. Months of acute suffering were experienced before these polypoid masses burst their surrounding walls.

M. D. LEDERMAN.

IV. LARYNX AND TRACHEA.

A Report of Two Hundred and Seventy-six Intubations—W. B. PUSEY—*American Practitioner and News*, November 15, 1899.

Of the cases intubated 48.5 per cent recovered. The most common accident that occurred was the pushing of the membrane down before the tube, but in one case only was it attended with serious results. In one case a tracheotomy had to be done.

SCHEPPEGRELL.

Motor Laryngeal Disturbances — GRABOWER — *Berl. Klin. Wochenschr.*, October 30, 1899.

The author is inclined to think that in some instances a diagnosis of paralysis of various laryngeal muscles is made, when a more careful examination would reveal the fact that the limited motion is the result of a mechanical hindrance. He cites a case of his own which seemed to be a paralysis of the right crico arytenoideus posticus with a secondary contracture of the right adductors. He, however, believes it to be a case of spurious anchylosis of the crico-arytenoid articulation. He gives his reasons in full, but it is necessary to read the paper at length to come to a clear understanding of his position. VITTUM.

The Treatment of Syphilitic Stenosis of the Larynx by Intubation—THOMAS C. EVANS—*Medicine*, December, 1899.

The author points out the advantages of intubation in chronic stenosis of the larynx over that of former methods of relief, like tracheotomy. It is superior in that no preliminary tracheotomy is necessary, if applied in time. The dyspnea is immediately and permanently relieved, the intubation tube dilating and divulsing the stricture, at the same time, by pressure, causing absorption of granulation tissue. The operation can be performed without shock or loss of blood, and with no danger from erysipelas, septicemia or pneumonia, and can be performed without an anesthetic.

The employment of the hard rubber tube is advised. STEIN.

The Cause and Treatment of Removing Laryngeal Stenosis Following Intubation — LOUIS FISCHER — *Medical Record*, December 2, 1899.

It is stated that this condition is primarily caused by forcibly pushing a tube into an edematous or infiltrated mucous membrane. O'Dwyer's observations led him to believe that the stenosis was due to using too large a tube in the hands of inexperienced operators.

The seat of the lesion which keeps up the stenosis is just below the vocal cords, in that portion of the larynx bounded by the cricoid cartilage. When the mucous membrane swells in this region the obstruction necessarily occurs towards the center, as the outside wall is cartilage. Consequently, to prevent traumatism, a small calibre tube should be employed. Granulations will also cause a recurrent dyspnea. Paralysis of the cords usually comes late in the disease. Tubes should be removed every three days to avoid irritation from calcareous deposits. These deposits will form only on metal and not on rubber tubes. If a tube has to be introduced more than twice, a medicated gelatin coating of a five or ten per cent alum solution is applied to the tube. The author has had good results from a ten per cent gelatin-ichthyol solution as a covering for the tube.

Specific stenosis is also mentioned, and is said to be always congenital. M. D. LEDERMAN.

Laryngitis Secondary to Nasal Disease—DUNDAS GRANT—*Journ. Laryn., Rhin. et Otol.*, October, 1899.

In the chronic congestive conditions, local applications of astringents are recommended after the nasal irritation has been eliminated. A ten (10) per cent solution of the chloride of zinc in rose water is preferred. This can be applied by means of a brush or spray. Cocaine is to be applied before. Rest of the voice and errors in voice production must be corrected.

"When the mucous membrane is simply sodden, rapid subsidence takes place. Then the nasal condition is improved, and a local astringent is applied. If, however, the white swelling of the mucous surface indicates proliferation of the epithelium," the author highly recommends the application of salicylic acid in strengths increasing from one to five per cent, the following combination, *i. e.:*

Salicylic acid	5 to 25 grains
Rectified spirits	5 drachms
Glycerine	3 drachms

Before applying this formula, cocaine should be employed. This solution should be limited as much as possible to the part affected, which it rapidly bleaches. It must be used with precaution, as it is quite irritating. The greater amount of epithelial proliferation, the greater is the indication for the employment of salicylic acid in increasing strength. In cases without epithelial hyperplasia this remedy is contra-indicated.

Where the thickening is limited to the interarytenoid space, salicylic acid is particularly indicated and well borne.

The writer has applied this solution with good results in a case of recurrent papillomata of the larynx. A number of cases of other conditions of the larynx are reported. LEDERMAN.

Intubation in Private Practice—J. TRUMPP—*Münchener Med. Wochenschr.*, November 7, 1899.

The principal object of this paper seems to be the discussion of the question as to whether intubation is justifiable where continuous medical supervision cannot be exercised. In order to speak with authority, the author obtained the results of eighty-nine European and American physicians who had performed the operation at private houses where constant supervision by a physician was impossible. These men reported in all 5,468 intubations with 36 per cent of cures in the pre-serum period, and 81.98 per cent of cures when used in conjunction with serum. In these 5,468 cases only 13 cases of death by accident were reported. Two cases of death from obstruction of the tube, ten cases of auto-extubation and one case of suddenly recurring stenosis after extubation.

This extremely small percentage of accidents seems to show that intubation in private houses is justifiable, and the author gives a long list of conditions under which obstruction of the tube and auto-extubation may occur.

His final conclusions are as follows:

1. Every physician in general practice should strive to perfect himself in the technique of intubation as well as of tracheotomy.

2. Intubation is unequivocally demanded when there is immediate danger of suffocation and there is no time for tracheotomy; also if permission to perform tracheotomy is refused.

3. The physician is justified in performing intubation at a private house and without permanent medical supervision.

(a) If the patient cannot be moved to a hospital.

(b) If the relatives decide in favor of intubation after the comparative advantages and dangers of tracheotomy and intubation have been explained to them.

(c) If communication between the house and the physician is easy and the latter can reach the house within an hour of any accident.

(d) If all other precautions for the safety of the patient have been taken.

4. Intubation in private practice should be an early operation whenever possible, inasmuch as the results are the best where the patient's strength is still only slightly impaired and the local process not greatly developed.

5. Inasmuch as tracheotomy presents so many more difficulties than intubation in private practice, it should only replace the endolaryngeal method when the above-mentioned conditions cannot be complied with, or when intubation has failed to relieve, or where the presence of the tube has given rise to ulceration, or where the tube is repeatedly coughed up.

6. If tracheotomy is indicated, it should only be performed with tube in position. VITTUM.

Tubercular Laryngitis—J. R. MCINTOSH—*Maritime Medical News*, November, 1899.

The remedies recommended are: Lactic acid, 10 per cent, applied on a cotton swab, and the strength of the solution gradually increased even up to 90 per cent; menthol in 20 per cent solution of olive oil or liquid vaseline. As sedatives: Cocaine, orthoform and morphia.

In the ensuing discussion, Dr. Walden reported a successful case of tubercular laryngitis where tracheotomy had been performed.

GIBB WISHART.

Laryngological X-Ray Work—WADSWORTH WARREN—*The Medical Age*, October 25, 1899.

The discovery of Professor Roentgen has accomplished less, possibly, in the field of laryngology than in any other branch of medical science. It has been of service along the following lines: In the detection of foreign bodies, or, rather, their accurate location; in determining the time of ossification of the cartilages of the larynx; in the diagnosis of intrathoracic growths, and in the early diagnosis of tubercular processes in the lungs.

ALICE EWING.

V. EAR.

Diminished Bone Conduction as a Contra-Indication for Ossiculectomy—DUNDAS GRANT—*Journ. L., R. et O.*, October, 1899.

In chronic non-suppurative inflammation of the middle ear with fixation of the stapes, and some involvement of the contiguous parts of the internal ear, the removal of the outer ossicles is not likely to offer much improvement.

When, however, the outer ossicles are fixed and hamper the movements of a presumably or possibly mobile stapes, their removal is indicated on account of the hearing-power, apart from other and even weightier considerations. If, however, the ossicles are of functional value, they should not be removed.

Diminished bone conduction even in post-suppurative cases is a contra-indication. When hearing is so bad that the patient cannot follow his employment, it is justifiable to remove the outer ossicles and remains of the membrane, even though bone conduction is diminished. LEDERMAN.

Some Practical Remarks on the Anatomy of the Temporal Bone with Demonstrations—EMIL AMBERG—*The Physician and Surgeon*, November, 1899.

The variations in the relationship of the various parts relative to disease of and operation on the ear are dwelt on at length. The importance of a large opening at the beginning of the mastoid operation is emphasized. The author prefers the chisel and mallet as the main instruments for operation, and decries the employment of a trephine as used by some for cutting out a plug of skin, to be followed by the use of a boring drill and dental bur. STEIN.

The Contagiousness of Acute Suppurative Inflammations of the Middle Ear—M. LERMOYEZ—*Journ. L., R. et O.*, Dec., 1899.

According to this observer, acute otitis media suppuration is contagious. It is not an obvious and unavoidable contagion, but quite a possible transmission. This statement, however, does not apply to all forms of this affection. Seven cases are cited to corroborate the above opinion.

The contagion takes place through the naso-tubal route. It commences in a coryza, which may be so attenuated that clinically it passes unperceived.

The author's observations tend to prove the following opinion: *given the first patient affected with influenza complicated with otitis, any other influenzal patient put in contact with him will run a great risk of acquiring this otitic complication.* (Italics are the authors.)

He believes that otitic cases should be isolated.

M. D. LEDERMAN.

A Study of Aural Vertigo—Lewis S. Somers—*Medicine*, January, 1900.

Vertigo consists of a symptom complex, of which the essential feature is the sensation of moving, or the appearance of movement of objects, when there is no real existence of such. It may be subjective or objective, and varies from a slight dizziness to utter inability to maintain the equilibrium. Any cause acting on the tension of the intra-labyrinthal fluid and disturbing its normal equilibrium will produce vertigo. This may arise from anemia, hyperemia, inflammatory changes in the middle ear, ankylosis of the ossicles, adhesion of the stapes to the oval window, or obstruction of the external auditory canal, as by cerumen.

Cerebral disease, disturbance of the function of the vestibular nerve, pressure on the auditory nerve, derangement of the eyes, disorders of viscera, and toxemia are also causes. Irritation of the labyrinth is an indispensable factor in the production of vertigo as is shown by the fact that it does not arise if the labyrinth is totally destroyed. This irritation may be found in all cases if carefully sought. Detwiler.

Deafness Due to Mumps—Ed., *N. Y. Med. Journ.*, Dec. 16, '99.

In a short note upon this subject, referring to an article which had appeared in the *Gazetta des hôpitaux*, it is stated that the pathogeny remains obscure, and most authors think there is a sanguineous effusion into the labyrinth. Treatment is of no avail as regards the power of hearing, but the vertigo may be benefitted by the use of quinine. Dr. E. D. Spears, of Boston, however, believes that we may avert such a dismal sequel, by placing the patient in bed, and employing subcutaneous injections of pilocarpin. He thinks that many cases of effusions into the labyrinth can be and have been cured by this treatment. M. D. Lederman.

Inflammation of the Middle Ear and Sequelæ—Thos. McDavitt—*Northwestern Lancet*, January 1, 1900.

The tonsils are so frequently the gateway of infection to the middle ear that they should not be overlooked in any case and, if found at fault, should receive due attention. In the treatment of the middle ear, heat yields the best results in controlling the inflammation and pain. Cold is to be avoided because its continued use depresses the vitality of the parts to which it is applied. Should bulging of the drum membrane appear, he incises it at the most dependent portion. After paracentesis he avoids frequent syringing with water, occasionally applies peroxide of hydrogen, drying thoroughly afterwards, and insufflates an antiseptic powder that will not pack, as acetanilid, 25 parts and boric acid, 75 parts. If the mastoid becomes infected, he promptly removes all diseased tissue and makes free drainage for pus. D. W. Detwiler.

Inflation and Medication of the Middle Ear in Non-Suppurative Otitis Media—E. OLIVER BELT—*Maryland Med. Journ.*, December 30, 1899.

The author advocates the more common use of the compressed air apparatus with a nebulizer in preference to the other methods. As objections to the Politzer's method, he states, that children are frightened by it, and will not allow its use the second time. Elder people are shocked by its suddenness, and suffer strangulation from the water held in the mouth. The drumhead is sometimes ruptured, especially when drumhead is thinned by atrophic changes.

The principal objection to use of the catheter is the bruising or abrasions caused by the passage of same. The method advocated by the author is, viz.: the naso-pharynx is first sprayed with a modified Dobell's or similar solution, which not only cleans but reduces the turgescence of the mucous membrane, thereby enlarging the caliber of the nasal passages and Eustachian tube, thus making inflation easier. A pressure of from ten to twenty-five pounds is preferred in the compressed air apparatus. The air is passed through a globe nebulizer, where it can be medicated if desired, and the force and suddenness of the rush of air is modified by the elasticity of the rubber tubes through which it passes. The patient is directed to puff the cheeks out, the nose tip is placed in one nostril, and with a Davidson cut-off on the air apparatus, the air is allowed to enter one nostril and escape through the other. If the obstruction in the Eustachian tube is marked, a few drops of a 4 per cent cocaine solution applied by a cotton applicator will alleviate matters. One of the advantages by this method is, that by quickly opening and closing the Davidson cut-off, vibratory movements or massage can thus be given the drumhead and ossicles. Medication of the middle ear can be accomplished by placing the desired medicine in the Globe nebulizer or by direct injection of the medicated fluid through the catheter. The writer is opposed, however, to the use of injections of fluids into the middle ear, through the Eustachian tube. E. D. LEDERMAN.

Mastoiditis—E. L. HOLT—*Journ. of Med. Science*, October, 1899.

Temperature is not a positive guide for the detection of mastoiditis, as it is not uncommon to have extensive inflammation of this process without much rise of temperature.

The author calls attention to those cases which could not be taken by the usual symptoms. Under these conditions (where the patient is subject to attacks of earache accompanied by chills and fever, but has gone on to resolution without any serious results) and the posterior and superior part of the meatus, next to the membrane is reddened and swollen, and tender to the probe, the mastoid should be opened. Where the latter symptoms exist, with true tenderness upon deep pressure, the writer has always been warranted in performing the operation. LEDERMAN.

Four Cases of Otitis Media—VAUGHN PENDRED—*Lancet*, November 18, 1899.

The importance of early operation in cases of infection of the mastoid cells is generally recognized, and the cases recorded are very good examples of the benefit following a thorough operation. In the fourth case it is, indeed, difficult to account for the paralytic symptoms being on the same side of the body as the ear disease and the resulting disease of the brain, but it is most probable that there existed some undetected mischief on the right side of the brain. Another remarkable point in these cases is the presence of the fly in the ear of a boy in Case 3; it is not impossible that the sudden cessation of the discharge from the ear was due to a blocking of the aperture by the fly, or it is possible that it was the original cause of the disease of the middle ear. It is generally admitted that delay in operating on a patient exhibiting symptoms, however equivocal, of intracranial mischief and suffering from otitis media is unjustifiable. The above cases illustrate in a very striking manner the danger of procrastination, and the excellent results which are to be obtained by early "surgical interference." Cases 1 and 4 demonstrate that even with a free discharge from the ear very serious mischief may be occurring within the cranium, although the symptoms are not more striking than an attack of sickness, as in the child, or of severe headache, as in the man. The author is utterly at a loss in Case 4 to explain the left-sided hemiplegia, when the only demonstrable lesion of the brain was on the same side. There would appear in Case 3 (perhaps the most striking of the group) to be a causal connection between the fly and the ear trouble. The great cell extending upwards from the apex of the mastoid and displacing the lateral sinus is unusual, in the first place because this part of the bone, as a rule, consists of a honeycomb of small cells, and in the second place because the boy had not attained puberty, at which age the mastoid cells are described as developing. Case 2 was remarkable as demonstrating the great value of opening up the mastoid antrum for the relief of the pain of the middle-ear disease. Taken together, the cases show how ill-defined the symptoms are liable to be, the classical picture of earache with swelling over, and intense tenderness of, the mastoid process, and accompanied by sickness and fever, not being presented by one of the group in its entirety.

STCLAIR THOMSON.

Osteoplastic Opening of the Mastoid—DR. KÜSTER, Marburg—*Centrallblatt für Chirurgie*, October 28, 1899.

The outer ear is drawn sharply forward, and an incision is made close along its posterior border, beginning a little above the level of the external auditory opening. This incision passes downward around the tip of the mastoid and is then carried upward along the posterior border of the latter to the same level where it was begun. This U-shaped cut is carried down to the periosteum, which is then pushed aside with a raspatory and a shallow groove cut into the

bone with a chisel all along the incision. With a broad chisel, a thin plate of bone is then split off, beginning at the bottom. This plate is of course adherent to the soft tissues, and the whole skin-periosteum-bone flap can be turned upward, leaving the field of operation free.

In order to replace the flap nicely it may be necessary to bite off a little from its lower end so that a drain may be led from the cavity made by the operation to the outside. The author reports briefly nine cases operated on in this manner. He claims as the advantages of this method, little deformity, rapid healing and a good opportunity for the tampon in case the sinus or the dura mater are injured during the operation. VITTUM.

Mastoiditis: The Importance of Early Surgical Treatment—J. F. McCAW—*New York Med. Journ.*, December 30, 1899.

In doubtful cases, the author regards the sagging of the postero-superior cutaneous covering of the external auditory meatus close to the membrana tympani as indicative of pus in the mastoid cells. In conclusion he states that:

(1) In threatened mastoid involvement and in mild acute cases the conservative plan of treatment should be first tried for at most a week or ten days, unless dangerous symptoms arise.

(2) Operative interference should be instituted *(a)* in acute cases where there is sagging of the postero-superior canal wall; *(b)* where the infection is of a virulent nature; and *(c)* in all cases complicating chronic otorrheas. LEDERMAN.

Mastoiditis—HILLARD WOOD—*Southern Practitioner*, November, 1899.

The four indications for opening the mastoid cells, as laid down by Schwartze, are as follows: "In acute inflammation of the cells, with retention of pus, if edematous swelling, pain and fever do not subside after antiphlogosis and free incision. In chronic inflammation of the mastoid process with subacute (periosteal) abscesses or fistulæ in the mastoid. With a sound cortex of the mastoid, on account of cholesteatomata or purulent retention in the middle ear, which cannot otherwise escape, and with which symptoms arise showing that the life of the patient is in danger, or when a congestive abscess has formed in the upper posterior wall of the meatus. When the mastoid appears healthy and there is no pus in the middle ear, but when the mastoid is the seat of long-continued and unendurable pain which other means fail to relieve."

Schwartze's further advice not to operate when secondary meningitis, metastatic pyemia or brain abscess has developed, while conservative, is not so generally endorsed by good operators. In opening the mastoid cells the author prefers the chisel to the drill.

W. SCHEPPEGRELL.

The Relation of Sinus Disease and Meningitis to Purulent Disease of the Middle Ear—WALKER SCHELL—*Indiana Medical Journal*, December, 1899.

In a boy nine years old with an otorrhea and all the symptoms of a meningitis, the necropsy showed the sigmoid and in part the lateral sinus darkly discolored the dura, petrous and occipital bones. There was present a cerebro-spinal lepto-meningitis purulenta, external and internal, taking its origin of infection through the aqueductus cochlear. Large numbers of purulent cholesteatomatous masses were found throughout the petrous portion of the temporal bone and especially in the osseous labyrinth, where the semicircular canals were involved. STEIN.

Remarks Upon the Operative Treatment of Infective Thrombosis of the Sigmoid Sinus, Following Chronic Purulent Otitis Media—Record of a Case Successfully Treated—A. YOUNG—*Glasgow Med. Journ.*, October, 1899.

The case here recorded is one of very considerable interest. The patient was aged two and one-half years and since an attack of measles six months previously, had suffered from a discharge from the left ear. Three weeks before the onset of serious symptoms, the discharge had ceased. With this cessation, there had developed drowsiness, failure in appetite, starting and crying at night. Six days before admission a large subperiosteal abscess had commenced to form behind the left ear. On examination, temperature, 100.2F.; pulse, 140–150 per minute; respirations, 46–50 per minute; there was intense drowsiness, a persistent and spasmodic half sigh, half yawn; pupils equally dilated; no paralysis of face or limbs; pale earthy complexion; dry, coated tongue; a persistent, troublesome cough; a large swelling behind ear; the left meatus and middle ear contained very foul, dried pus; there was some swelling in the upper part of both cervical triangles, but no tenderness over the left internal jugular vein. After evacuating the subperiosteal abscess, two erosions were found, one anteriorly leading into the antrum, the other posteriorly passing into the sigmoid groove. The antrum and tympanum were cleared out, the posterior meatal wall removed, and the sigmoid sinus exposed for fully half an inch; the posterior wall of the antrum was eroded into the sigmoid groove. The sinus was covered with granulations and pus, and looked black and unhealthy. Some of the bone behind the sinus was removed and the cerebellar dura exposed; the tegmen tympani and tegmen antri were also removed, there being erosions in that situation; though the sinus felt somewhat hard to the finger it was not opened. Distinct improvement followed the operation, but on the second day a rise of temperature and the very doubtful appearance of the sinus led to the opening of the latter. A fetid dark gray disintegrating clot was evacuated. The temperature which at first fluctuated finally became normal and complete recovery ensued.

A. LOGAN TURNER.

VI. DIPHTHERIA, THYROID GLAND, ESOPHAGUS, ETC.

Three Cases of Foreign Bodies in the Esophagus—Tracheotomy and Esophagotomy in One Case—H. L. MAITLAND—*Austral. Med. Gaz.*, November, 1899.

The first case was a woman, aged twenty-nine, who had swallowed a portion of a dental plate four months before, which could not be located by skiagraph. There was intense dyspnea, cyanosis and abundant muco-purulent sputum. The foreign body was located in the esophagus about opposite the cricoid cartilage. The low operation of tracheotomy was done with immediate relief. Esophagotomy was then done and the dental plate removed. The wound was left open and plugged with iodoform gauze. The wound healed in five weeks.

In the second case, a child, aged eight months, was said to have swallowed a safety-pin. Nothing could be felt in the throat; a skiagraph revealed the pin in the esophagus, about one inch below the level of the sternal notch.

It was decided, owing to the position of the pin (which was open and point upwards), to push it down into the stomach under chloroform. This was done by means of a Belfast linen bougie. The child had no furthur discomfort, and passed the pin by the bowel four and a half weeks later.

The third case was that of a miner, aged thirty-four, with an abscess about the size of a small orange on the left side of his neck, about the level of the cricoid cartilage. He stated that three weeks before he had swallowed a safety-pin, and that his neck had begun to swell three days after. A small incision was made along the posterior border of the sterno-mastoid where the abscess was pointing. The pin was felt by the scalpel on making the incision, and was easily withdrawn. The wound was plugged with gauze and the patient fed by nutrient enemas for five days; the wound healed in a month. EATON.

Asthma in Relation to the Upper-Air Passages—P. MCBRIDE, Edinburgh—*Edinburgh Med. Journ.*, July, 1899.

The author deals mainly with the subject of nasal asthma, but briefly refers to asthma associated with lesions in other parts of the upper respiratory tract. Under the first heading he discusses hay fever, which in certain persons is followed by asthma. He next refers to the presence of nasal polypi as a cause, dwelling upon the fact that in his experience small polypi are more liable to bring on an attack than large growths, a circumstance which possibly may be due to the greater mobility of the former causing more irritation to the mucous membrane. A third group of cases is found associated with hypertrophic catarrh and deviations of the septum. Sometimes the pathological condition is obvious and so marked as to interfere with nasal respiration, in other cases the deviations

may be very slight, so as hardly to justify the term pathological, and then the difficulty arises as to whether any surgical interference should be carried out. If, however; the bronchial attack be preceded by sneezing and nasal hypersecretion, the application of the electric cautery may be beneficial by destroying nerve endings and by binding down erectile tissue by the formation of cicatrices. In other cases again, the author has found by means of the probe "cough spots" upon the nasal mucosa; when those reflex areas are obtained they should be touched with the electric cautery, as their presence in these asthmatic cases certainly indicates intra-nasal treatment. In other cases again, even where no nasal symptoms or objective signs exist, it is possible that the application of the cautery may prove a valuable counter-irritant. The author has very rarely found asthma associated with a lesion of any other part of the upper respiratory tract. With regard to prognosis, a cure should not be promised after operative interference, as the existence of asthma depends upon some individual predisposition.

A. LOGAN TURNER.

Diagnosis and Treatment of Diphtheria—T. W. RANKIN—*Columbus Medical Journal*, Dec. 30, 1899.

An early diagnosis of diphtheria is of the utmost importance. Both bacteriological and clinical methods should be used, and neither one relied on to the exclusion of the other.

The mere presence of the bacilli in the throat does not prove the presence of diphtheria nor does a failure to find them under certain conditions disprove its presence.

The bacilli may disappear early, they may not be found if antiseptics have been applied shortly before using the swab, if there is no membrane, or if it has disappeared, and if the precaution to go into the crypts of the tonsils with a probe is not taken. The secretions of the throat are apt to be misleading early in laryngeal cases and late in pharyngeal cases. Clinical manifestations should have careful consideration. The neglect of these symptoms and the delay of treatment until a bacteriological diagnosis is made is responsible for many disastrous results. In fully four-fifths of the cases a correct clinical diagnosis can be made in twenty-four hours. In treatment, hygienic, dietetic and medicinal measures of known value should not be neglected.

No prejudices should be allowed to deprive the patient of the benefit to be derived from antitoxin. D. W. DETWILER.

Diseases of the Eye, Ear, Nose and Throat in the Negro—E. C. ELLETT, Tenn.—*Memphis Medical Monthly*, December, 1899.

The negro enjoys a singular immunity from catarrhal inflammation, but is prone to tuberculosis and syphilis. Hypertrophied tonsils are rare, tonsillitis uncommon. Adenoids do not occur in the negro. SCHEPPEGRELL.

A Case of a Melon Seed in the Left Bronchus. Operation. Recovery—G. W. ARMSTRONG—*Australas. Med. Gaz.*, Sept., 1899.

A child 18 months old when seen was apparently suffering from bronchitis, with marked distress of respiration and elevated temperature. Nine months before while playing with melon seeds one of them was sucked into the windpipe. Since then there has been frequent violent paroxysmal attacks of coughing, during some of which the parents thought the child must succumb.

On examining the chest evidences were found of the seed being impacted in the left side, where breathing was seriously interrupted, very little air entering a larger part of the base of the lung.

The case was referred to Dr. W. Cleaver Woods who found that the foreign body was not tightly fixed, but had an interval in the tube—perhaps an inch or two in length—up and down in which it slipped with respiration. Two days later Dr. Woods witnessed a terrible convulsive fit which looked very like instant operation to save life.

The trachea was opened in the usual way, placing the handle of the scalpel in the tube crossways, and holding it there well against the posterior wall. The usual violent respiratory action which immediately followed served to dislodge the seed, and it was twice ejected against the handle of the knife, each time, however, being sucked back into the bronchus. The opening was now enlarged with scissors upwards and downwards and the blade of the knife depressed toward the chin, whereupon the seed was blown upwards along the handle of the knife and out upon the table. The trachea was closed with catgut sutures. The child made an uninterrupted recovery. EATON.

Gastrostomy for Traumatic Stricture of the Esophagus—Report of a Case—GEORGE BEN JOHNSTON—*North Carolina Med. Journal*, December 5, 1899.

After all efforts to insert the esophageal bougie failed, a gastrostomy after the method of Ssabanajew-Frank was done. Dilitation was then attempted with success, so that now a No. 12 bougie may be passed through the stricture. SCHEPPEGRELL.

Antitoxin in Diphtheria—CHRISTOPHER C. CRONKHITE—*Indiana Medical Journal*, December, 1899.

The author cites two cases and arrives at the conclusion that in all cases of so-called false croup, no matter how mild the symptoms, antitoxin should be used immediately. STEIN.

Antitoxin—O. W. ARCHIBALD—*Northwestern Lancet*, Jan., 1900.

This writer adds to the already long list of cures of diphtheria by antitoxin and reports two severe cases cured by this remedy. His experience also emphasizes the advisability of administering the serum early. D. W. DETWILER.

VII. INSTRUMENTS AND THERAPY.

The Use of Suprarenal Capsule Extract in Surgery of the Ear, Nose and Throat—W. W. BULETTE—*Denver Med. Times*, November, 1899.

In the experience of the author with suprarenal extract there has been little secondary hemorrhage after its use, not so much post-operative swelling, and the healing process is much more rapid than where cocaine is used alone. He is of the opinion from actual trials, that local anesthesia cannot be induced with cocaine and the extract by the aid of cataphoresis as thoroughly by other methods of applying these drugs, and further that cataphoresis induces hemorrhage. He has seen no unpleasant systemic effects from the use of the extract, but on the contrary has observed fewer cases of cocaine toxemia than formerly. EATON.

Methylene Blue as a Local Application in Diseases of the Mucous Membrane, with Report of Three Cases—CHARLES MOIR—*American Pract. and News*, Dec. 1, 1899.

The pus-destroying properties of methylene blue are equal, if not superior, to any drug we have. In one to five per cent solutions it is non-irritating. The author reports a case of tonsillitis and one of nasal catarrh in which it appeared to be of benefit.

SCHEPPEGRELL.

Climatic Treatment of Tuberculosis—F. E. WAXHAM—*New York Medical Journal*, December 23, 1899.

There is no climate suitable to all cases. The climate must be adapted to the patient. Tuberculous cases should be sent westward early. Rest and increased nourishment plays an important part in the treatment of this disease. Invalids, instead of exercising when first reaching a change of atmosphere, should take long hours of rest, and, if fever is present, should remain in repose until same has subsided.

It is a sad mistake to send patients in the last stages of this terrible affliction away from home and friends. M. D. LEDERMAN.

Creosote in Tuberculosis—S. GOLDSTEIN—*Galliards Med. Journ.*, August, 1899.

In an experience with eighteen cases of pulmonary and laryngeal tuberculosis, and in the glandular enlargements of the diathesis, the author concludes, after a trial of many excipients, that the combinations of maltine and beechwood creosote are the happiest. They are easily administered, being palatable; are of fully tested assimilability, offers increased nutrition and are unaffected by temperature variations. He considers beechwood creosote a valuable drug in these conditions. F. C. E.

BOOK REVIEWS.

Masters of Medicine—H. von Helmholtz. By JOHN GRAY MCKENDRICK, M.D., LL.D., F.R.S.S.L. and E., of Edinburgh. 8vo., cloth and gilt, 300 pp., $..... Longmans, Green & Co., 91 Fifth Ave., New York, Publishers.

Under the caption, "Masters of Medicine," the publishers have undertaken a praiseworthy work in furnishing the profession and the world of science and art with an excellent series of complete biographies of some of the greatest minds in medical science.

The most recent publication of this series is the biography of von Helmholtz, one of the greatest minds of the Nineteenth Century, a physicist without a peer, whose original researches and contributions to light and sound have become world renowned.

The author very ably combines biographical incidents with a record of the achievements in scientific discovery and inventions of this great master in physics, giving an outline of the paths along which he trod, and presenting a sketch of the branches surveyed by von Helmholtz, and then adding an account of his contributions and researches in these fields.

The volume includes a characteristic portrait of von Helmholtz. The publishers are to be congratulated on the typographical beauty of this series, and this particular volume of the series should be in the library of every otologist interested in the history and early development of his science.

General and Local Anesthesia. By AIMÈ PAUL HEINECK, M.D., of Chicago. 124 pages, $1.00. G. P. Engelhard & Co., Publishers, 358-362 Dearborn St., Chicago.

This handy volume includes many valuable suggestions, especially the consideration of local anesthesia in otology, rhinology and laryngology.

With the considerable application of anesthesia in otology, rhinology and laryngology it is necessary that we should familiarize ourselves with the many details in the use of local and general anesthetics. In our text-books devoted to these special fields of medicine, this subject is usually dismissed with a few words. This little manual fills a necessary literary niche.

Die Missbildungen des Gaumens und ihr Zusammenhang mit Nase, Auge und Ohr. (*Deformities of the Palate and their relations to the Nose, Eye and Ear.*) By DR. FRITZ DANZIGER, Beuthen, Germany. Monograph, 52 pp., 13 illustr., 4 lithographic plates. J. F. Bergmann, Wiesbaden, publisher; Lemcke & Buechner, 812 Broadway, N. Y., American agents.

Careful researches concerning deformities of the superior maxilla and its adjacent areas and attachments, form the subject of this original monograph. Special consideration is given to abnormal forms and their causes. The conclusions reached by the author are somewhat at variance with the generally accepted theories on this subject.

In considering the malformations of the jaw, the author includes: 1. An abnormally high palatal arch. 2. The alveolar arch, which diverges from the shape of a U to that of a V. 3. Retarded growth of the palate, causing a lack of space for the proper distribution of the teeth, and the consequent forcing out of line of some of the teeth. 4. A ridge of the alveolar arch occurring in the median line.

Basing his conclusions on observations of these deformities, the author describes the influences brought to bear on the nose, eye and ear.

A detailed understanding of the author's conclusions can be gleaned only by a careful perusal of the monograph. Special diagrams and plates are presented to elucidate the text.